Meaningful protection or unacceptable risk?

A critical analysis of undue influence as a safeguard in proposed voluntary assisted dying legislation in South Australia

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Abstract

Legalisation of voluntary assisted dying ('VAD') has been a recurrent issue before the Parliament of South Australia, with the introduction of 24 bills into the legislature over the past 25 years. Although VAD has been successfully enacted elsewhere in a shorter space of time, the divisive nature of this topic is reflected in the lengthy time between drafting and enactment in South Australia. One pertinent issue that arises in the ongoing debate is how a request for VAD can be adequately protected from inappropriate external pressure, which resulted in the introduction of the doctrine of undue influence as a proposed statutory safeguard in several VAD bills.

This thesis challenges the reliance on the doctrine of undue influence as a statutory safeguard in proposed VAD legislation in South Australia, arguing that instead of providing meaningful protection of a voluntary decision, it has the unintended consequence of placing individuals involved in the process at risk of harm. It is argued that 'undue influence' does not have an ordinary meaning and is conventionally understood as a legal term of equitable origin, consequently rendering it infelicitous as a proposed statutory safeguard for a voluntary decision. It asserts that the legislature's continued failure to define and clarify the scope of undue influence renders it an ambiguous, and consequently inappropriate, test.

This thesis concludes by urging the South Australian legislature to critically examine reliance on the doctrine of undue influence as a mechanism to protect a voluntary decision, recommending that an expert multidisciplinary committee be convened to conduct further research on this specific issue. It is posited that the data concerning the statutory response to safeguarding a voluntary consent in other jurisdictions, although beneficial as it serves as a point of reference, be viewed through a cautious lens, as there

is a lack of convincing evidence demonstrating that voluntariness can be rigorously protected. VAD will become lawful in the near future in South Australia, as the *Voluntary Assisted Dying Act 2021* (SA) has passed through both Houses of Parliament and will commence operation on a day to be fixed by proclamation. It is imperative that further research is undertaken to devise an appropriate test to ensure meaningful protection of a voluntary decision. There is no scope for error here, as no adequate remedy can be awarded to compensate for a non-voluntary death.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree. I acknowledge that copyright of published works contained within this thesis resides with the copyright holder(s) of those works. I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

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Signed: *Michaela Estelle Okninski* Dated: *13 January 2022*

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This thesis is dedicated to my beautiful children.
Your inquisitive minds often leave me in a state of wonder.
May you never stop questioning the way the world works!

Safeguarding a voluntary decision in proposed voluntary assisted dying legislation in South Australia

[1.10] Legalisation of voluntary assisted dying ('VAD') has been a recurrent matter before the Parliament of South Australia for over 25 years, resulting in the introduction of 24 VAD bills into the State legislature. Although many of the bills differed in substance and form, one consistent characteristic among them is that they all recognised the need to safeguard a decision for VAD against external pressure by incorporating a suite of protections into the proposed statutory framework to meet this purpose. Whilst safeguarding the voluntariness of decision-making was a core substantive protection of each iteration, the majority of the bills introduced in the 2010s sought to heighten protections against external pressure by placing a positive obligation on medical practitioners and lay witnesses to screen for undue influence on an individual requesting VAD. This thesis challenges the reliance on the term 'undue influence' as a statutory safeguard in proposed VAD legislation in South Australia, arguing that it is infelicitous and is unlikely to provide meaningful protection of a voluntary decision.

The doctrine of undue influence is predominantly understood as a legal term, most familiar to legal professionals well-versed in equity and probate. As a consequence of its legal lineage, undue influence is a complex term that does not yield to a single definition. In 2017, the High Court of Australia addressed the definitional ambiguity with undue influence, observing that 'no court has ever attempted to define undue influence. One reason for the difficulty of defining undue influence is that the label "undue influence" has been used to mean many different things.'[1] Although the doctrine of undue influence has

[1] *Thorne v Kennedy* (2017) 350 ALR 1, 11 [30] (Edelman J for Kiefel CJ, Bell, Gageler and Keane JJ) (citations omitted).

been expressed in a variety of different ways, the general underlying principle that undue influence aims to protect is the integrity of decision-making by recognising that external influence or pressure placed on a person to consent to a decision can vitiate their free will and agency, in certain circumstances. In equity and law, the courts will not permit a decision to stand if it was not expressed voluntarily but procured through overbearing external pressure.[2]

Undue influence was initially solely recognised by the jurisdiction of equity, then later adopted and modified by the probate courts and subsequently recognised as a ground to challenge the validity of a consent to medical treatment. Therefore, undue influence operates as a ground to challenge the validity of a contract, transfer of property or a substantial gift, testamentary instrument or consent to, or refusal of, medical treatment as the case may be. However, in these separate areas of equity and common law, undue influence has distinct meanings which have been shaped by the nature of the law, the interest being protected and the surrounding judicial narrative. Consequently, the transformation of undue influence from a legal doctrine into a statutory safeguard in the novel area of VAD is concerning.

In law, words and phrases often have a distinct meaning that are unfamiliar to the English lexicon. Hence, not all legal terms are amenable for use outside of the legal sphere. However, a likely consequence of the increasing prevalence of legislation of a source of law in Australia[3] is that legal terms that have a long judicial history are being inserted into

[2] For complete discussion on the doctrine of undue influence in equity, probate and common law see Chapter 15.
[3] For discussion on the increasing prevalence of legislation in contemporary Australia see generally Murray Gleeson, 'The Meaning of Legislation: Context, Purpose and Respect for Fundamental Rights' (2008) 82(9) *Law Institute Journal* 52.

novel contexts without critical reflection regarding how well the transplantation will work in practice.[4] The inclusion of undue influence as a statutory safeguard in VAD legislation is an exemplar of this incongruity. The South Australian legislature introduced the doctrine of undue influence into unfamiliar milieu without explication or guidance for medical practitioners and lay witnesses — members of the general public — called upon to be arbiters of this question. This is risky. Further, it is unclear whether undue influence can ever be translated into a meaningful safeguard for a voluntary decision for VAD due to the complex judicial history of the doctrine.

This thesis does not challenge the South Australian legislature's motivation for establishing a robust framework of statutory safeguards aimed at providing rigorous protection of a voluntary decision. Broad protection of a voluntary decision is mandatory in an area such as VAD. This thesis rather stands as a critical reflection on the legislature's choice of terminology and argues that if protection against undue influence is to operate well as a statutory protection, then clarity concerning the scope and operation of the test is mandatory. The failure to critically evaluate how undue influence would enhance protection of a voluntary decision demonstrates a misunderstanding of the doctrine of undue influence. As it stands, it is an ambiguous test, shrouded in uncertainty. Instead of providing meaningful protection of a voluntary decision, it has the unintended consequence of placing patients and medical practitioners at risk of harm. This is unacceptable when the risk to patients is a non-voluntary death and the risk to medical practitioners is responsibility for something that they cannot identify or understand, potentially leading to professional disciplinary action.

[4] For discussion on the inclusion of complex legal terminology in the space of VAD legislation, see Jocelyn Downie and Kate Scallion, 'Foreseeably Unclear: The Meaning of the "Reasonably Foreseeable" Criterion for Access to Medical Assistance in Dying in Canada' (2018) 41(1) *Dalhousie Law Journal* 23.

The scholarly discussion on undue influence in proposed voluntary assisted dying legislation

[1.20] Legalisation of VAD is undoubtedly a controversial issue that raises a myriad of complex concerns.[5] A frequent tension that arises in the ongoing debate, however, is how to balance respect for individual autonomy by expanding end-of-life choices to include VAD, whilst ensuring that individuals are not pressured against their will to partake in it. Indeed, it is difficult to balance these competing interests and there is unlikely to ever be consensus on this aspect of the debate. However, as more jurisdictions in the Western world, now including South Australia,[6] enact VAD legislation, recognition of the need to protect people from abuse is a legitimate concern and is not challenged here.[7] Indeed, the deference given to protection of a voluntary decision in jurisdictions where VAD is permitted is evidence enough that protection against behaviour which operates to undermine it is a vital issue.[8] For instance, data from Oregon, USA, demonstrates that older individuals — likely to fall into the category of persons considered vulnerable to abuse — are more likely to access VAD than their younger counterparts.[9] When

[5] For a broad overview of the competing issues raised in the ongoing debate see John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2018); Emily Jackson, 'In Favour of Legalisation of Assisted Dying,' in Emily Jackson and John Keown (eds), *Debating Euthanasia* (Hart Publishing, 2012); Gunter Lewy, *Assisted Death in Europe and America: Four Regimes and their Lessons* (Oxford University Press, 2011); Julia Warren, Nucef Yeksel and Saxon Smith, 'Avoiding a Fate Worse than Death: An Argument for Legalising Voluntary Physician-based Euthanasia' (2012) 20(1) *Journal of Law and Medicine* 184; see also Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, June 2016) 303-13.

[6] Voluntary Assisted Dying Bill 2020 (SA) ('VAD Bill (SA)') passed the South Australian legislature on 24 June 2021; see South Australia, *Hansard,* Legislative Council, 24 June 2021, 3917.

[7] This was indeed a concern in the recently passed VAD Bill (SA) where it is explicitly stated in the principles of the Bill that 'every person has the right to make decisions about medical treatment options freely and not as a consequence of the suggestion of pressure, coercion or undue influence of others' see VAD Bill (SA) s 8(1)(k). This feature was not included in the initial version of the Bill but was introduced as an amendment at the Committee stage in the House of Assembly: see South Australia, *Hansard,* House of Assembly, 9 June 2021, 5973, 5990-94.

[8] This is considered in detail in Part 2.

[9] The latest activity report on physician assisted dying released from the state of Oregon, USA, indicates that 81% of individuals who participated in physician assisted dying in 2020 were aged over 65, and since the Act came into force, 64.2% of individuals were aged over 65: see Public Health Division – Center for Health Statistics, Oregon Death with Dignity Act 2020 Data Summary, *Oregon Health Authority*, 3, 9 (26 February 2021)

considered against the backdrop of the increasing prevalence of elder abuse in Australia, which has been deemed an issue of national priority and the subject of a Royal Commission in the past 12 months,[10] fears that legalising VAD may potentially lead to abuse among older South Australians is indeed justified.

On this point, Warren, Yuksel and Smith remark that a frequent argument raised against legalisation of VAD is that 'pressure will be applied to people nearing the end of their natural life to seek euthanasia if it is legally sanctioned,'[11] highlighting that 'some families treat their elderly or unwell family members with love and compassion while others view them as a burden and their care as tiresome'.[12] Although, this thesis is not focussed specifically on the impact legalising VAD in South Australia will have on older South Australians, it remains a valid concern.[13] It is important to clarify the position adopted here, being that the framework proposed to safeguard against undue influence falls short of providing meaningful protection of a voluntary decision, which is a matter of concern for *all individuals* who may request VAD, not just the elderly. It is acknowledged that categorising individuals — for instance, older South Australians, individuals with a disability, women and uneducated persons — into vulnerable groups is a precarious

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>.

[10] In response to the increasing prevalence of older abuse in Australia, the Council of Attorneys-General in Australia have initiated a national plan to address the growing issue of older abuse in Australia: see Council of Attorneys-General, National Plan to Response to the Abuse of Older Australians (Elder Abuse) 2019-2023, *Australian Government – Attorney-General's Department*, 8 July 2019 <https://www.ag.gov.au/rights-and-protections/publications/national-plan-respond-abuse-older-australians-elder-abuse-2019-2023>; see also *Experimental Estimates of the Prevalence of Elder Abuse in Australian Aged Care Facilities* (Research Paper 17, December 2020) <https://agedcare.royalcommission.gov.au/publications/research-paper-17-experimental-estimates-prevalence-elder-abuse-australian-aged-care-facilities>; *Valuable Instrument or the Most Abused Legal Document in Our Judicial System?* A Review of the Role and Operation of Enduring Powers of Attorney in South Australia, *South Australia Law Reform Institute* (Report 15, December 2020) 220-260.

[11] Warren, Yeksel and Smith (n 5) 189.

[12] Ibid.

[13] The impact that legalising VAD would have on the elderly was also deemed an issue of importance before the Joint Select Committee on End of Life Choices in Western Australia: see Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (Report 1, August 2018) 68-73 ('JSC End-of-Life Choices (WA)'); see also Western Australia, *Hansard*, House of Assembly, 7 August 2019, 5136 (Roger Cook, Minister for Health).

position to take, as it erroneously adopts a paternalistic attitude toward them, which must be avoided. All individuals, for a variety of reasons, may be vulnerable to external pressure, which may include undue influence, at some point. The central argument is that undue influence as a statutory safeguard is unlikely to provide meaningful protection of a voluntary decision and further research is required to remedy this shortcoming. It is imperative to include safeguards that are capable of ensuring that voluntariness is truly protected.

Concerns that individuals will be improperly pressured or influenced into requesting VAD are widespread and are not new.[14] For instance, a key issue of concern, highlighted by the Social Development Committee of the Parliament of South Australia in 1996 was that, 'it would be difficult, if not impossible, to ensure that all acts of euthanasia were truly voluntary.'[15] This anxiety was reflected in 2008 by South Australian Senator, Stephen Wade, who opined that 'it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary'.[16] This issue was raised again multiple times when the Voluntary Assisted Dying Bill 2020 (SA) was being debated before the Committee in the House of Assembly in June 2021.[17] On a similar note,

[14] For broader discussion on this see, eg, Select Committee on Medical Ethics, Parliament of the United Kingdom, *Medical Ethics: Select Committee Report* (HL Paper 21, May 1994) 1346; Health and Sport Committee, The Scottish Parliament, *Stage 1 Report on Assisted Suicide (Scotland) Bill* (SP Paper 712, 2015) 31-2; New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (Final Report, May 1994); Special Senate Committee on Euthanasia and Assisted Suicide, Parliament of Canada, *Of life and Death* (Final Report, June 1995); Report of the Joint Committee of Physician-Assisted Dying, Parliament of Canada, *Medical Assistance in Dying: A Patient-Centred Approach* (Report, February 2016).
[15] Twelfth Report of the Social Development Committee, Parliament of South Australia, *Inquiry into the Voluntary Euthanasia Bill 1996* (Report, October 1999) ix.
[16] South Australia, *Hansard*, Legislative Council, 28 October 2008, 3773 (S.G. Wade).
[17] South Australia, *Hansard*, House of Assembly, 9 June 2021, 5954-55 (Adrian Pederick); South Australia, *Hansard*, House of Assembly, 9 June 2021, 5955-59 (Tony Piccolo); South Australia, *Hansard*, House of Assembly, 9 June 2021, 5973, 5991-94 (Steve Murray); see also South Australia, *Hansard*, House of Assembly, 26 May 2021, 5704-05 (Sam Duluk).

the Final Report into *End of Life Choices* in Victoria noted that a pivotal concern raised by opponents of VAD was that 'legalising assisted dying poses a threat to vulnerable members of society [as] they will be subjected to pressure and subtle coercion [*undue influence*] to seek assisted dying'.[18] Similar views have been expressed throughout Australia.

Tangentially, in Western Australia, the Joint Select Committee on End of Life Choices highlighted inadequacies regarding the response to safeguarding a request for VAD against external pressure in selected USA jurisdictions, where it was argued that 'simply requiring a physician to tick a box stating that the person requesting assisted suicide [VAD] is no guarantee that the physician has the competence or has undertaken the extensive and careful inquiries necessary to establish that the person is not subject to undue influence or subtle pressure'.[19] Dr Khorshid of the AMA (WA), however, focused on the obligations placed on medical practitioners to evaluate the voluntariness of a request, observing that 'medical practitioners are not skilled in legal decisions … we are not skilled in knowing whether coercion is occurring'.[20] In Queensland, a similar concern was raised where palliative care physician Dr Gerard Purcell reflected that 'it is my experience the person who chooses freely and without external influences is a hard person to find. People … approach death in as many varied ways as there are people. But despite this variation approaching death without feeling the pressure of external influences is rare.'[21]

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[18] Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, June 2016) 309 ('*Inquiry into End of Life Choices*'). Protection of individuals who may be vulnerable to abuse or coercion was a matter of concern when the Voluntary Assisted Dying Bill 2017 (Vic) ('VAD Bill (Vic)') was introduced into parliament and provisions were specifically included to address this concern: see Explanatory Memorandum, VAD Bill (Vic) cls 35, 66. This was also a key issue of concern before the Joint Select Committee of End of Life Choices in Western Australia: see JSC End-of-Life Choices (WA) (n 13).

[19] JSC End-of-Life Choices (WA) (n 13) 69.

[20] Ibid 70.

[21] Health, Communities, Disability Services and Domestic Violence Prevention Committee, Parliament of Queensland, *Voluntary Assisted Dying* (Report No 34, March 2020) 83.

Thus, it is evident from this selected overview of the literature that protection of a voluntary decision has always drawn considerable discussion from a variety of perspectives.[22] This sentiment is not limited to the respective state parliamentary committees and is also prevalent in the existing academic discourse.

[1.30] Criticism of the legislative response to safeguarding a voluntary decision has been a topic of scholarly interest. For instance, Battin et al, remark that 'warnings about potential abuse [including pressure to request VAD] have been voiced by many task forces, courts and medical organisations in several countries where the issue is under debate.'[23] Although, Battin et al's research intended to dispel concerns that vulnerable populations were overrepresented in the data, thus more likely to access VAD, the authors asserted nonetheless that 'we must take these concerns seriously, not only because they are repeated so often but because they are of such gravity'.[24]

On the other hand, in Foley and Hendin's edited collection of essays against the implementation of VAD,[25] Cohn and Lynn address the impractical reliance on undue influence as a statutory safeguard in Oregon, USA, explicating that 'while it is hard enough to bar decisions made under threat of violence, gentle coercion [undue influence] of the

[22] This issue was also alluded to, although not considered in detail, in the Joint Committee on End of Life Choices, Parliament of South Australia, *Report of the Joint Committee on End of Life Choices* (Report, October, 2020); see Part 2 for detailed discussion statutory safeguards aimed at protecting a voluntary decision against external pressure; see also Explanatory Memorandum, VAD Bill (Vic) cls 85, 86; Western Australia, *Hansard*, House of Assembly, 7 August 2019, 5136 (Roger Cook, Minister for Health); University of Tasmania, *Independent Review of the End of Life Choices (Voluntary Assisted Dying) Bill 2020* (Report, February 2021).

[23] Margaret Battin et al, 'Legal Physician Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups"' (2007) 33(1) *Journal of Medical Ethics* 591, 591.

[24] Ibid. See also Emily Jackson, 'In Favour of Legalisation of Assisted Dying' in Emily Jackson and John Keown (eds), *Debating Euthanasia* (Hart Publishing, 2012) 47-53.

[25] Kathleen Foley and Herbert Hendin (eds), *The Case Against Suicide: For the Right to End of Life Care* (Johns Hopkins University Press, 2002).

very sick is hard to discern or to prevent.'[26] In a separate publication, Keown directs his frustration at the shortcomings of the statutory safeguards under the *Voluntary Assisted Dying Act 2017* (Vic) ('*VAD Act* (Vic)'), remarking

> … how are two medical practitioners, who need not be independent, or have any expertise in psychiatry or palliative care or have any previous knowledge of a patient, to ensure, on the basis of minimal contact with the patient over a little more than a week, that the patient's request is truly voluntary and informed [and] not the result of coercion or undue influence?[27]

Continuing his critique of the *VAD Act* (Vic), Keown highlights that protection against undue influence has, however, been omitted from the statutory framework of protections,[28] with medical practitioners' duty limited to ensuring that the person requesting VAD is acting voluntarily and without coercion.[29] Thus indicating that protection against coercion alone is insufficient, as there exists a surfeit of behaviour, including undue influence, that can equally undermine the voluntariness of a decision.

Thus, a consistent feature of the ongoing VAD debate is the issue of voluntary consent; that is, the concern that individuals will be pressured into requesting VAD and consideration of how to adequately safeguard a decision to request VAD from such pressure. The concerns articulated above are wide-ranging in the sense that the arguments posited are diverse and there is no consensus on whether adequate protection of a voluntary decision can be achieved. It is not the mandate of this thesis to resolve this ongoing tension in the existing literature, nor is it to put forward an argument for, or against, legalisation. Such arguments are not practicable as, for better or worse, VAD is now part of South Australian law. Rather, the position adopted here is that providing broad protection of a voluntary decision is vital in something as serious as VAD. However,

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[26] Felicia Cohn and Joanne Lynn, 'Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide' in Kathleen Foley and Herbert Hendin (eds), *The Case Against Suicide: For the Right to End of Life Care* (Johns Hopkins University Press, 2002) 257.
[27] John Keown, 'Voluntary Assisted Dying in Australia: The Victorian Parliamentary Committee's Tenuous Case for Legalization' (2018) 33(1) *Issues in Law and Medicine* 55, 81.
[28] The legislation only includes undue influence as an offence: see *VAD Act* (Vic) ss 85, 86.
[29] See Keown (n 27).

the response proposed by the South Australian legislature raises concerns. Therefore, this thesis will critique the reliance on the term 'undue influence' as a proposed statutory safeguard in VAD legislation as it reflects an inappropriate adoption of a complex legal term resulting in flawed protection of a voluntary decision.

The gap addressed by this thesis

[1.40] This thesis clearly serves as a critique of VAD legislation. However, where it departs from the existing academic discourse is that it is a critique of proposed VAD legislation from a South Australian perspective. To further refine the scope of this discussion, and to delineate it from existing research, this thesis focuses on a very specific aspect of the proposed statutory framework of consent; that is, the requirement that consent for VAD be voluntary. In South Australia, the response to ensure that this objective was achieved resulted in, inter alia, placing a positive obligation on medical practitioners and the general public to act as witnesses to actively screen for undue influence in a request for VAD.

In undertaking a comprehensive analysis of VAD bills tabled in the South Australian parliament from 1995–2016, it was observed that the majority of bills tabled in the 2010s increased statutory protections for a voluntary decision by obligating medical practitioners and lay witnesses to certify that the individual requesting VAD was not acting under undue influence. Undue influence was not defined and no explication was provided in the respective VAD bills or the *Hansard* regarding how protection against undue influence was to operate in practice. Reliance on undue influence as a proposed statutory safeguard in VAD legislation in South Australia is the central issue examined here. Critical examination of undue influence in the novel area has never been undertaken

before. Therefore, this thesis serves as a foundational discussion on a specific aspect of the statutory framework of consent, potentially acting as a catalyst for further research.

The South Australian legislature passed VAD legislation weeks before this thesis was due to be submitted for examination[30] and, despite this historical move, VAD in South Australia is far from resolved. The legislature now has the enormous task of implementing it throughout the State, which is predicted to take between 12–18 months.[31] Thus, this discussion is unique, as it considers law reform for VAD from a uniquely South Australian perspective, critically evaluating one of the substantive safeguards that aim to protect the voluntariness of decision making, contributing timely, pragmatic research on a highly relevant topic in South Australia.

The impact that the passing of the *Voluntary Assisted Dying Act 2021* (SA) has on this thesis

[1.50] The South Australian legislature passed the *Voluntary Assisted Dying Act 2021* (SA) ('*VAD Act* (SA)' or 'the Act') on 24 June 2021 and now joints a select handful of jurisdictions around the world to permit VAD.[32] However, at the time of writing, VAD still remains illegal in South Australia until such time as the *VAD Act* (SA) comes into force.[33] Due to the recency of this development, it is imperative to clearly establish the parameters of this discussion and to address the impact this has on this thesis. The predominant issue that arises is that the framework of protections incorporated to safeguard voluntary

[30] The impact that the passing of the *Voluntary Assisted Dying Act 2021* (SA) has on this thesis will be considered below at **[1.50]**.
[31] See, eg, Sarah Mullins and Jessica Harmsen, 'How will South Australia's new Voluntary Assisted Dying Legislation Work? And when will it come into force?' *ABC News* (Online, 25 June 2021) <https://www.abc.net.au/news/2021-06-24/how-does-sa-voluntary-assisted-dying-law-euthanasia-work/100238874>.
[32] These jurisdictions are considered in Part 2.
[33] See s 2.

consent in the *VAD Act* (SA) differs from the previous framework proposed in the bills tabled in parliament during the 2010s.[34] It was considered above at **[1.40]** that this thesis critiques the adoption of the legal term 'undue influence' as a proposed statutory protection for VAD legislation in South Australia. This phrase has been removed from the Act as a safeguard but was retained in a more limited way which is set out at **[1.60]** below. Victoria set a precedent for other states by enacting the *VAD Act* (Vic), which ultimately served as a model legislation for other states,[35] including South Australia, resulting in a rethinking of the response to protect a voluntary decision.

In passing the *VAD Act* (SA), South Australia largely mirrored the *VAD Act* (Vic).[36] This was indeed evident when the bill was being debated before parliament,[37] where it was reiterated that this legislative framework largely mirrored the requirements established in the *VAD Act* (Vic).[38] Consistent with the Victorian approach, the South Australian legislature abandoned screening for undue influence as a statutory safeguard, adopting the phrase used in the *VAD Act* (Vic) 'acting voluntarily and without coercion'.[39] Although omission of the term 'undue influence' as a proposed statutory safeguard in the *VAD Act* (SA) may be perceived as an issue of concern for the substance of this thesis, it will be considered at **[1.60]** below that this discussion remains valuable, as the South Australian legislature failed to critically evaluate the statutory safeguards that seek to protect a voluntary consent, thus representing a missed opportunity.

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[34] These have been listed in Table 5.
[35] See, eg, *Voluntary Assisted Dying Act 2019* (WA).
[36] For general discussion on how other Australian jurisdictions may respond to the implementation of the *Voluntary Assisted Dying Act 2017* (Vic), see Ben White and Lindy Willmott, 'Future of Assisted Dying Reform in Australia' (2018) (42)(6) *Australian Health Review* 616.
[37] See South Australia, *Hansard,* House of Assembly, 2 December 2020, 3540 (Susan Close, Deputy Leader of the Opposition); South Australia, *Hansard*, Legislative Council, 2 December 2020, 2346 (Kyam Maher, Leader of the Opposition).
[38] See South Australia, *Hansard*, Legislative Council, 2 December 2020, 2346-50 (Kyam Maher, Leader of the Opposition).
[39] See *Voluntary Assisted Dying Act 2017* (Vic) s 20(1)(c); cf *Voluntary Assisted Dying Act 2021* (SA) ss 38(1)(c), 47(1)(c), 64(c)(iii), 82(2)(a)(ii).

[1.60] When the VAD Bill (SA) was being debated before the Committee in the House of Assembly, two amendments were carried which focussed on increasing the primacy given to voluntariness. The first of these amendments introduced an additional provision into the principles section, stating that 'every person has the right to make decisions about medical treatment options freely and not as a consequence of the suggestion, pressure, coercion or undue influence of others'.[40] The second of these amendments sought to include an additional eligibility criterion stipulating that in order to be eligible to request VAD, 'the person must be acting freely and without coercion'.[41] Although acting voluntarily and without coercion already existed as a statutory safeguard,[42] the new amendment sought to include it as a condition to access VAD.[43] The impetus behind this amendment was to reinforce parliament's 'view that a lack of coercion is important [and] enshrined as a criterion for access',[44] further solidifying the legislatures intent to ensure that voluntariness was prioritised.

It is clear that the legislature intended to tighten the response to protecting a voluntary decision, going further than the *VAD Act* (Vic). These amendments, however, stop short of imputing clarity and guidance into the statutory framework of safeguards. Whether the legislature is using undue influence as a protection against inappropriate pressure or

[40] See VAD Bill (SA) s 8(1)(k); South Australia, *Hansard*, House of Assembly, 9 June 2021, 5973 (Steve Murray).
[41] VAD Bill (SA) s 14(1)(e); South Australia, *Hansard*, House of Assembly, 9 June 2021, 5990-94 (Steve Murray).
[42] See VAD Bill (SA) ss 26(1)(c), 35(1)(c), s 40(2)(a)(i), 52(c)(iii), 70(2)(a)(ii), 71(1)(c). References to the VAD Bill (SA) here are referring to the version as passed in the House of Assembly see Government of South Australia, Voluntary Assisted Dying Bill 2021 (SA), *Attorney-General's Department* (Web Page) <https://www.legislation.sa.gov.au/LZ/B/CURRENT/VOLUNTARY%20ASSISTED%20DYING%20BILL%202021_HON%20KYAM%20MAHER%20MLC.aspx>.
[43] This is analogous to the approach adopted in Western Australia: see *VAD Act 2019* (WA) s 16(1)(e). Furthermore, protection of a voluntary decision is more comprehensive under the *VAD Act* (WA) which vests State Administrative Tribunal (WA) with the jurisdiction to review a medical practitioner's determination concerning whether the person was acting voluntarily and without coercion in requesting VAD see s 84; cf *VAD Act* (Vic) s 68; cf *VAD Act* (SA) s 85.
[44] South Australia, *Hansard*, House of Assembly, 9 June 2021, 5993 (Steve Murray).

simply referring to it in passing in another section of the Act still results in ambiguity. Furthermore, the reason for excluding undue influence as a proposed statutory safeguard was not the process of a reasoned and well-informed debate. Instead, this was a result of the legislature largely mirroring the *VAD Act* (SA) off the *VAD Act* (Vic), where undue influence was excluded as a statutory safeguard. It is, therefore, likely that the Parliament of South Australia remains unaware to the issues that arose due to the previous reliance on undue influence as a statutory safeguard in the historical VAD bills tabled in the 2010s. There is a clear inconsistency regarding the response to protecting against coercion and inclusion of undue influence as a principle in s 8(1)(k).[45] Section 8(1)(k) states that 'every person has the right to make decisions about medical treatment options freely and not the consequence of the … coercion or undue influence of others'.[46] The issue that arises is that if everyone has the right to make healthcare decisions free from coercion and undue influence, how is this right upheld if only screening for coercion is mandatory under the *VAD Act* (SA)? Specific reference to coercion and undue influence in s 8(1)(k) indicates that they are distinct terms; however, only screening for coercion is mandated. Therefore, it is evident that further research on the operation and scope of the provisions that aim to protect a voluntary decision is required. This incongruity also demonstrates that there is still significant uncertainty concerning the statutory safeguards that aim to protect a voluntary decision, thus rendering the recommendations posited at the close of this thesis pertinent. Although, undue influence has been excluded as a specific statutory safeguard at the screening level, significant uncertainty remains concerning the statutory protections for a voluntary decision as no definition was included in the law.

Limits of this thesis

[45] *VAD Act* (SA) s 8(1)(k).
[46] Ibid.

[1.70] The focus of this thesis is intentionally narrow; that is, its aim is to critically evaluate the inclusion of undue influence as a statutory safeguard in proposed VAD legislation in South Australia, focusing on one specific aspect of the decision-making process, which is that consent must be voluntarily given and not procured by improper pressure such as undue influence. This is not an evaluation of the entire framework of consent proposed in the many VAD bills tabled in the Parliament of South Australia. A project of such considerable scope could not be adequately addressed within the confines of a doctoral thesis. As such, issues such as capacity to consent – also a legal term – and the appropriateness of other statutory safeguards have not been considered. Excluding these issues from consideration in no way suggests that they are not problematic. It simply reflects the fact that they could not be considered within the confines of this discussion.

Moreover, it is necessary to clarify the cut-off date for research. VAD is an area that is continuously under development. This issue presented a significant challenge to the writing of this thesis. For instance, in Part 2, I provide a comparative discussion of VAD laws internationally. To ensure that this discussion remained up-to-date, multiple revisions were required, which was time-consuming. Consequently, it was necessary to enforce a cut-off date of 1 December 2020. Materials and resources published after this point in time have not been considered here, *unless* they are significant to the central issue such as the passing of the VAD Bill (SA).

The passing of the *VAD Act* (SA) occurred only several weeks prior to submission of this thesis. The impact of this development was discussed above at **[1.60]**. It is necessary to clarify, however, that this Bill has not been incorporated into the primary discussion that follows, which is focussed on the bills tabled in parliament from 1995–2016, with

emphasis on the bills tabled in the 2010s. The reason for excluding the *VAD Act* (SA) from consideration here is that it was such a recent development that incorporating significant discussion of it into this thesis was not possible. Furthermore, whilst the Bill has been passed, information concerning how VAD will be implemented throughout South Australia remains to seen, thus acting as a limitation on further discussion. The impact that this recent development has on this thesis has been clearly justified in **[1.60]** above, thus avoiding any concern that may arise as a consequence of its exclusion.

Methodology

[1.80] This is a purely doctrinal thesis, by way of legal analysis. As such, primary and secondary sources of law will be consulted throughout. The central argument is that undue influence is primarily known as a legal doctrine and reliance on undue influence as a proposed statutory safeguard is infelicitous. The issue that arises as a consequence of its inclusion as a statutory protection is that it fails to provide meaningful protection of a voluntary decision and instead exposes the parties called upon to determine questions of undue influence to unnecessary risk of harm. These issues will be explored in detail here through a strictly legal lens, beginning with a detailed consideration of the primacy afforded to protection against undue influence from a South Australian perspective, followed by a careful analysis of the law in other jurisdictions, both national and international. To defend the argument that undue influence is inappropriate to operate as a statutory safeguard in proposed VAD legislation, careful consideration of the doctrine of undue influence in equity and law will demonstrate that it is a blunt tool, shrouded in uncertainty and ambiguity.

Part 1

[1.90] Part 1 serves to establish the landscape of this discussion, clarifying the scope of the issues considered and laying the foundation for the narrative that follows. The aim of Part 1 is threefold. First, the terminology used throughout this thesis will be explained and clarified. Second, a clear line will be drawn delineating existing lawful end of life practices and VAD, which despite recent developments, remains unlawful as the *VAD Act* (SA) is yet to come into force. This overview of end-of-life practices is important as it is here that the gap VAD attempts to bridge becomes apparent. This Part will then explore the repeated attempted law reform for VAD in South Australia, where it is observed that over time there was an increase in the parliamentary response to safeguard a voluntary decision against external pressure, resulting in the introduction of screening for undue influence as a statutory protection, thus clearly identifying the central problem this thesis will address.

Part 2

[1.100] Part 2 shifts focus, analysing VAD legislation in jurisdictions where it is currently permitted; that is, selected jurisdictions in Australia, USA, Canada (including the Province of Quebec), and the Netherlands, Belgium and Luxembourg. The rationale behind undertaking a comparative analysis of VAD laws here is that when researching attempted VAD law reform in Part 1, it was observed that the experience of other jurisdictions pervaded the ongoing debate in South Australia. Therefore, an analysis of these laws was necessary to gain further insight into the legislative response established in other jurisdictions to safeguard voluntary consent, which could be used as a point of reference to establish a more robust system of safeguards recommended in South Australia. This

Part will critically evaluate the statutory response to protecting a request for VAD against undue influence and, more broadly, other forms of improper external pressure. This legal critique will intricately examine the legislative response to safeguarding a voluntary consent, highlighting nuances that exist on this point in the jurisdictions considered. This analysis demonstrates that whilst there is a broad recognition of the need to safeguard a request for VAD against a variety of improper pressures, including undue influence, there is minimal discussion concerning how the key terms are defined and how these pivotal protections operate in practice. The uncertainty and ambiguity concerning the scope and operation of voluntariness safeguards is problematic. South Australia is now implementing VAD, the data published from these jurisdictions on this specific aspect of regulation is valuable, however, should be viewed through a cautious lens.

Part 3

[1.200] Part 3 of this thesis will focus on the issue at the heart of this thesis; that is, reliance on the doctrine of undue influence as a proposed statutory safeguard for a voluntary decision. This discussion will begin with a consideration of undue influence in the jurisdiction of equity, where it was first formed, and then discuss subsequent expansion into probate. This thesis explains that undue influence has distinct application in equity and probate, with the respective courts attributing their own rules and definition to the doctrine. The discussion demonstrates that undue influence is an inherently complex term burdened by its history, which renders it unfit for use as a statutory safeguard for a voluntary consent in the context of VAD. The issues that are likely to arise consequent upon the reliance on undue influence will be considered, where the risk to the main players — patients and medical practitioners — will be clearly articulated. Upon consideration of these issues, it is obvious that undue influence as a statutory safeguard

is a test that is not fit for purpose and further research into how to provide meaningful protection of a voluntary decision is essential.

> Issues of life and death do not lend themselves to clear definition and, without that, it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary.[1]

[1] South Australia, *Hansard*, Legislative Council, 28 October 2008, 3689, 3773 (S.G. Wade).

Introduction

[2.10] This thesis challenges the appropriateness of undue influence as a safeguard in proposed voluntary assisted legislation ('VAD') in South Australia, questioning whether it provides meaningful protection of a voluntary decision or exposes parties to unacceptable risk. VAD remains unlawful in South Australia, although the *Voluntary Assisted Dying Act* 2021 (SA) ('*VAD Act* (SA)') passed the legislature on 24 June 2021.[2] From 1995-2016, 23 VAD bills were tabled in the Parliament of South Australia. An examination of these bills revealed clear gaps in the efforts to safeguard against a tainted decision-making process, with the suite of protections including screening for duress, coercion and undue influence; the latter of which is the focus of this discussion. Given that VAD involves legalising acts that result in the intentional ending of life, it is needless to say that VAD is a controversial issue. The quote from the South Australian *Hansard* above aptly encapsulates a key issue with legalising VAD — the difficulty in safeguarding a voluntary consent — which remains a matter of parliamentary concern, with much of the debate focused on this issue. In direct response to this there has been a consistent and significant legislative focus on protection of voluntary choice, and this has translated into a legislative adoption of the equitable concept of undue influence to safeguard a voluntary consent.

Prior to engaging in this critique on undue influence in VAD, it is first necessary to establish the legal landscape and address important preliminary matters that are essential to this narrative. This thesis is unique as it is examining VAD from a South Australian perspective, which has largely been overlooked in the existing scholarly

[2] The *Voluntary Assisted Dying Act 2021* (SA) ('*VAD Act* (SA)') will come into force on a day to be fixed by Proclamation: see s 2.

literature.[3] Therefore, insight into existing law and attempted law reform in this State is necessary. Additionally, terminology is important to this discussion and the drawing of a clear line between lawful and unlawful end-of-life practices is mandatory. To ensure consistency and clarity throughout this discussion, the chosen terminology will be explained. Presently, no universal term exists to define the practice of what now referred to as 'VAD' in South Australia, as each jurisdiction generally adopts its own language.[4] The variations in terminology, however, can be a source of confusion and clarity on this point is essential. Furthermore, VAD is often viewed as an extension of end-of-life law and practice, due to the limited circumstances in which it often applies.[5] Therefore, it is necessary to begin this discussion with an overview of existing legal practices in this space and distinguish them from VAD.

Thus, the aims of this chapter are twofold. The first objective is to clarify the terminology used throughout this thesis; and the second is to compare and contrast VAD with existing lawful end-of-life practices in South Australia. Although the South Australian legislature recently passed the *VAD Act*, at the time of writing, it has not yet come into force. Therefore, VAD remains illegal in South Australia.

Terminology

[2.20] According to the leading institution on health law research in Australia — Queensland University of Technology's Australian Centre for Health Law Research ('ACHLR') — the preferred term in Australia is 'VAD'. White and Willmott observe that the

[3] For a general overview on the history of failed law reform for VAD in South Australia see Lindy Willmott, Ben White, Christopher Stackpoole, Kelly Purser and Andrew McGee, '(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics' (2016) 39(1) *University of New South Wales Law Journal* 1.
[4] For an overview of terminology, see Table 1.
[5] This is indeed reflected in ss 26(1)(d)(i)-(iv), 26(1)(e) of the *VAD Act* (SA).

shift in terminology from 'euthanasia' to 'VAD' only recently occurred and evolved 'through State and Territory law reform inquiries into end of life choices, as well as parliamentary debates … of laws enabling a terminally ill person to seek medical assistance to die'.[6] However, it is important to note that other existing terms are still commonly used in this area, which are 'euthanasia', 'physician-assisted suicide', 'physician-assisted dying' and 'Medical Assistance in Dying' (MAiD). Consistent with the position adopted by ACHLR — and the title of the *VAD Act* (SA) — this thesis will adopt the term 'VAD' when discussing the law and attempted law reform in South Australia. When discussing the law in other jurisdictions, for the sake of clarity, the terminology used there will be adopted.[7] However, the exception to this rule applies when engaging in a general discussion on VAD, which will revert to the term of choice, 'VAD'. For clarity of argument, this Chapter will use the old terminology, drawing distinctions and similarities with the practices permitted in other jurisdictions, including South Australia.

What is euthanasia?

[2.30] The word 'euthanasia' is a broad term, often used to include a wide range of distinct, albeit associated, practices. Although the delineation between practices in some cases is slight,[8] the difference is important, as it can often mean the difference between engaging in lawful and unlawful conduct.[9] The word 'euthanasia' itself comes from the Greek words *'eu'* and '*thanatos',* which translates to mean 'good death'.[10] This translation

[6] Ben White and Lindy Willmott, 'Euthanasia and Assisted Dying', *Queensland University of Technology End of Life Law in Australia* (Web page, 12 March 2020) <https://end-of-life.qut.edu.au/euthanasia>.
[7] See Table 1.
[8] See **[2.100]**-**[2.500]** below.
[9] See, eg, discussion on the US jurisdictions in Chapter 9.
[10] Lorana Bartels and Margaret Otlowski, 'A Right to Die? Euthanasia and the Law in Australia' (2010) 17 *Journal of Law and Medicine* 532, 532; see also Gunter Lewy, '*Assisted Death in Europe and America: Four Regimes and their Lessons*' (Oxford University Press, 2011) 3-5.

is essential to understanding the contexts in which euthanasia is sought, as it is often perceived as being a compassionate solution to unbearable pain and suffering.[11] More often than not, emotive connotations such as 'humane and dignified', 'compassionate' and 'peaceful' are included in most definitions of euthanasia and this is reflected in the titles of the many VAD bills.[12] However, which practices do — and do not — actually constitute euthanasia requires clarification.

For instance, practices such as the doctrine of double effect are not euthanasia and is lawful in South Australia.[13] Therefore, it is important to draw a clear distinction between different end-of-life treatments and interventions. The following discussion will delineate between the many categories of euthanasia and associated palliative care practices. This foundational discussion provides essential background information regarding the parameters of lawful end-of-life practices in South Australia. It is here at the boundary of lawful — and unlawful — that the consideration of the role of undue influence will begin.

Definitions of Euthanasia

[2.40] The literature surrounding how euthanasia is best defined is vast.[14] Critical of most definitions, Bagaric argues that 'the literature on euthanasia is rife with self-serving

[11] In jurisdictions that currently have permissive VAD laws, physical pain and suffering are not always a relevant criterion, rather eligibility alone can be based on the existence of a life limiting terminal illness. See, eg, *Oregon Death with Dignity Act*, ORS 127.800 ss 1.01(12), 127.805 2.01(1) ('*DDA* (Oregon)').
[12] See Table 6.
[13] See generally Ben White, Lindy Willmott and Michael Ashby, 'Palliative Care, Double Effect and the law in Australia' (2011) 21(1) *Internal Medicine Journal* 485. Several studies suggest that doctors have an insufficient understanding of the definitional distinctions in end-of-life practices. See D Neil et al, 'End-of-Life Decisions in Medical Practice: A Survey of Doctors in Victoria (Australia)' (2007) 33 *Journal of Medical Ethics* 721; Tinne Smets et al, 'Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross Sectional Analysis of Reported and Unreported Cases' (2010) 341 (7777) *British Medical Journal* 819.
[14] See generally John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2nd ed, 2018) 9–34; Mirko Bagaric, 'Active and Passive Euthanasia: Is There a Moral Distinction and Should There Be a Legal Difference? (1997) 5 *Journal of Law and Medicine* 143.

definitions… [and most] definitions are objectionable because they can be used to gain an undeserved definitional edge'.[15] This is true, especially when the euthanasia debate is confined to dichotomous moral, ethical and religious arguments, which is where Bagaric directs most of his frustration.[16] Questions of morality and religion, although important to many, are separate from this thesis, therefore avoiding these normative distinctions. Consequently, general, neutral definitions will be provided. However, the following definitions will describe the motivation for euthanasia as resting on an intention to relieve pain and suffering. This definitional stance is adopted because pain, suffering and/or the presence of a life-limiting terminal illness were generally mandatory eligibility requirements to access VAD under the SA bills.[17] Thus, consistent with the proposed eligibility requirements, they will be included accordingly. The prominent terms in this area are:

- Voluntary active euthanasia;
- Non-voluntary and involuntary euthanasia;
- Physician-assisted suicide.

Voluntary active euthanasia

[2.50] Voluntary active euthanasia is a process where a doctor intentionally ends a person's life at their explicit, voluntary request, usually to relieve pain and suffering. This is achieved by a doctor *actively* administering a lethal medication to an eligible person.[18]

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[15] Bagaric (n 14) 143-44.
[16] Ibid, 144. See also South Australia, *Hansard,* Legislative Council, 28 October 2008, 3689, 3775-777 (RD Lawson).
[17] It is noted that in the Netherlands and Belgium pain and suffering need not be physical, it can also be psychological. Additionally, throughout the selected jurisdictions in the USA, there is no requirement for the individual to be suffering at all. For further discussion on theses aspects of the law see generally Keown (n 14).
[18] Ben White and Lindy Willmott, 'Euthanasia and Assisted Dying', *Queensland University of Technology End of Life Law in Australia* (Web page, 12 March 2020) <https://end-of-life.qut.edu.au/euthanasia>; see

The term 'eligible person' is critical to the provision of voluntary active euthanasia, as there is no absolute right to receive euthanasia even in jurisdictions where it is currently permitted. In other words, specific conditions and requirements must be satisfied. If the person does not meet the defined eligibility criteria and the doctor proceeds regardless, then civil/criminal liability and/or professional disciplinary proceedings may be initiated.[19]

VAD is definitionally the same as active voluntary euthanasia and it is currently unlawful in South Australia.[20] That is, a medical practitioner commits an offence if they administer a lethal substance to a patient with the direct intention to end life. VAD is, however, permitted in Victoria and Western Australia, and will eventually be permitted in South Australia when the *VAD Act* (SA) comes into force.

Non-voluntary and involuntary euthanasia

[2.60] In addition to voluntary active euthanasia, two additional categories of active euthanasia exist: non-voluntary euthanasia and involuntary euthanasia. The basis of the voluntary and the non-voluntary/involuntary divide lies in the requirement to act with

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also Ben White and Lindy Willmott, 'How Should Australia Regulate Voluntary Euthanasia and Assisted Suicide?' (2012) 20 *Journal of Law and Medicine* 410, 412; *Voluntary Euthanasia Bill 2016* (SA) s 3 (definition of 'voluntary euthanasia'); S Burkhardt, R La Harpe, T-W Harding and J Sobel, 'Euthanasia and Assisted Suicide: Comparison of Legal Aspects in Switzerland and Other Countries' (2006) 46(4) *Medicine, Science and the Law* 287, 288; Rex Tauati Ahdar, 'The Case Against Euthanasia and Assisted Suicide' (2016) 3 *New Zealand Law Review* 459, 460-61.

[19] See, eg, Michael Cook, 'Belgian Trial is Unveiling Dark Back Story to Euthanasia Death to Tine Nys' *Bioedge* (26 January 2020) <https://www.bioedge.org/bioethics/belgian-trial-is-unveiling-dark-back-story-to-euthanasia-death-of-tine-nys/13305>; Michael Cook, 'Dramatic Euthanasia Trial Ends in Acquittal for all Three Belgian Doctors' (1 February 2020) <https://www.bioedge.org/bioethics/dramatic-euthanasia-trial-ends-in-acquittal-for-all-three-belgian-doctors/13314>; Gerrit van der Wal et al, 'Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands' (1996) *New England Journal of Medicine* 335(22) 1706.

[20] See **[1.50]** above for discussion on the *VAD Act* (SA).

explicit voluntary consent, which the former two practices do not require.[21] Non-voluntary euthanasia is a process where a medical practitioner intentionally ends a person's life, when they are incapable of giving consent, such as someone suffering from advanced Alzheimer's disease.[22] Involuntary euthanasia, on the other hand, is a process where a medical practitioner intentionally ends a person's life without explicit consent when that person is capable of giving it.[23] Bagaric asserts that of all the categories of active euthanasia, non-voluntary and involuntary are most the objectionable as they are not capable of being supported by the autonomy argument, which is most often used to justify legalisation of voluntary active euthanasia.[24] Non-voluntary and involuntary euthanasia are unlawful in South Australia, and all of Australia, and are punishable under criminal law.[25] Non-voluntary and involuntary are highly unlikely to ever become lawful in South Australia. They have never been a feature of any previous VAD bills because they reflect a generally unacceptable paternalistic intrusion of overriding individual choice.

Physician-assisted suicide

[2.70] Physician-assisted suicide represents a contrast to voluntary active euthanasia with respect to the level of involvement of the healthcare provider. It is best defined as a process where a medical practitioner assists a person to end their life, at their explicit

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[21] See generally Ben White and Lindy Willmott, 'Euthanasia and Assisted Dying', *Queensland University of Technology End of Life Law in Australia* (Web page, 12 March 2020) <https://end-of-life.qut.edu.au/euthanasia>.
[22] Sheila A M McLean, 'Law at the End of Life: What Next?' in Sheila A M McLean (ed), *Death, Dying and the Law* (Dartmouth Publishing Company Limited, 1996) 52.
[23] Ibid.
[24] Bagaric (n 14) 144-45. Furthermore, non-voluntary and involuntary euthanasia are reminiscent of Nazi Germany's state-run euthanasia program — Aktion (operation) T4 and Krakenmorde — where hundreds of thousands of German citizens deemed unfit for life due to physical and/or intellectual disability or other undesirable traits were involuntarily killed during the 1930s and 1940s. For further discussion see Michael Robertson, Astrid Ley and Edwina Light, *The First into the Dark: The Nazi Persecution of the Disabled* (UTS ePress, 2019).
[25] See *Criminal Law Consolidation Act 1935* (SA) ss 11, 13A.

request, by actively prescribing lethal medication to self-administer.[26] With both voluntary active euthanasia and physician-assisted suicide, the doctor's intention is to facilitate death at the person's request — subject to the criteria established in the relevant legislative framework. However, what differs is the means to achieve the desired end. Some jurisdictions do not differentiate between voluntary active euthanasia and physician-assisted suicide, meaning the legislative framework legalises both practices and adopts a single term to cover both. However, they are, by definition, distinct.[27]

For example, under the *Voluntary Assisted Dying Act 2017* (Vic), VAD has been defined generally, covering both practices of voluntary active euthanasia and physician-assisted suicide.[28] Section 3(1) defines 'voluntary assisted dying' as 'the administration of a voluntary assisted dying substance and includes steps reasonably related to such administration'.[29] However, the preference is for patient administration (physician-assisted suicide) of the lethal substance, with practitioner administration only permissible if certain additional criteria are met.[30] Another example of both practices being subsumed under the one term is found in previous VAD bills in South Australia, where the term 'voluntary euthanasia' was used to include both voluntary active euthanasia and physician-assisted suicide, even though they are defined separately.[31] Although 'physician-assisted suicide' is readily used in the literature, there has been some

[26] Ben White and Lindy Willmott, 'Euthanasia and Assisted Dying', *Queensland University of Technology End of Life Law in Australia* (Web page, 12 March 2020) <https://end-of-life.qut.edu.au/euthanasia>.
[27] However, this distinction is critical in the United States jurisdictions that have legalised some form of assisted dying as only physician-assisted suicide in legal there: see *DDA* (Oregon) § 3.14; see also Table 1 and Part 2 for further discussion.
[28] Section 3(1) (Definition of 'voluntary assisted dying') ('*VAD Act* (Vic)').
[29] Ibid.
[30] See Table 1 for further discussion.
[31] See, eg, Voluntary Euthanasia Bill 2016 (SA) s 18–20. An overview of all South Australian VAD bills is provided in Chapter 3.

contention with this term, based on a perceived definitional inaccuracy.[32] The underlying rationale for describing it as 'suicide' is that the act which causes death is completed by the individual and, when coupled with the requisite intention to end their life, this broadly satisfies the criteria of suicide. However, in selected jurisdictions in the USA where this practice is permitted, the definitional inaccuracy has been highlighted.[33] The motivation behind rejecting the term 'physician-assisted suicide' proffered by the American Public Health Association ('APHA') is that

> …profound psychological differences distinguish suicide from actions under DDA [*Oregon Death With Dignity Act*]. The American Psychological Association has recognized, 'it is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired my mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically [depressed] person uses to justify suicide.' Medical and legal experts have recognized that the term 'suicide' or 'assisted Suicide' is inappropriate when discussing the choice of a mentally competent terminally ill patient to seek medications that he or she consume to bring about a peaceful and dignified death.[34]

Therefore, critical to APHA's rejection of the word 'suicide' was the difference regarding the underlying motivations for death. In cases of suicide, the impetus to end life is driven by an underlying psychiatric/psychological illness, separate from the reasons a terminally

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[32] See, eg, Ben White and Lindy Willmott, 'Euthanasia and Assisted Dying' *Queensland University of Technology End of Life Law in Australia* (Web page, 12 March 2020) <https://end-of-life.qut.edu.au/euthanasia>.

[33] For early scholarly discussion on the subject, 'physician-assisted suicide' was readily used: see, eg, Linda L Emanuel (eds), *Regulating how we die: The ethical, medical, and Legal Issues Surrounding Physician-Assisted Suicide* (Harvard University Press, 1998); Margaret Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide* (McGill-Queen's University Press, 2001); Gerald Dworkin, R G Frey and Sissela Bok, *Euthanasia and Physician-Assisted Suicide* (Cambridge University Press, 1998); Herbert Hendin and Kathleen Foley, 'Physician-Assisted Suicide in Oregon: A Medical Perspective' (2008) 24(2) *Issues in Law and Medicine* 121. For examples of recent publication that reject the use of the term physician-assisted suicide, see Lawrence O Gostin and Anna E Roberts, 'Physician-Assisted Dying: A Turning Point?' (2016) 315(3) *Journal of the American Medical Association* 249; cf Ben White and Lindy Willmott, 'Euthanasia and Assisted Dying' *Queensland University of Technology End of Life Law in Australia* (Web page, 12 March 2020) <https://end-of-life.qut.edu.au/euthanasia>.

[34] Patients' Rights to Self-Determination at the End of Life, *American Public Health Association* (Web Page, 28 October 2008) (citations omitted) <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life>; see also David Orentlicher, Thaddeus Mason Pope, and Ben Rich, 'The Changing Legal Climate for Physician Aid in Dying' (2014) 311(19) *Journal of the American Medical Association* 1961.

ill person asks to end their life.[35] Consequently, the term of choice adopted in most jurisdictions in the USA is 'Death with Dignity.'[36] Although potentially misleading, it is the same as physician-assisted suicide and it too is unlawful in South Australia.

Overview of key terms used throughout this thesis

[2.80] There are several distinct practices that generally fall under the broad term 'euthanasia'. The delineation between these practices is important as the approach to legalising VAD differs between the permissive jurisdictions and not all practices are lawful.[37] For ease of reference, Table 1, provided at the close of this section, outlines the terms and practices adopted in this thesis.

As highlighted above, VAD is unlawful in South Australia. There are, however, other associated lawful practices that can be confused with voluntary assisted dying. A complete discussion, therefore, requires the drawing of a clear distinction between VAD and existing lawful practices. This discussion will be limited to an overview of existing law in South Australia, as a nation-wide analysis of these practices is beyond the narrow scope of this thesis.[38]

[35] See, eg, Thaddeus Mason Pope, 'Legal History of Medical Aid in Dying: Physician Assisted Death in US Courts and Legislatures' (2018) 48(2) *New Mexico Law Review* 267, 297–98.
[36] See *DDA* (Oregon) §3.14.
[37] See Table 1 and Part 2 for further discussion.
[38] For discussion on practices in other states, see especially Ben White and Lindy Willmott, 'Euthanasia and Assisted Dying' *Queensland University of Technology End of Life Law in Australia* (Web page, 12 March 2020) <https://end-of-life.qut.edu.au/euthanasia>.

Table 1 – Overview of practices and terminology by jurisdiction

Jurisdiction	Medical Practitioner Administration Only	Patient Administration Only	Both	Terminology Adopted in this Thesis
1. Belgium			✓	Voluntary Euthanasia[39] (VE)
2. The Netherlands			✓	Voluntary Euthanasia and Assisted Suicide (VE/AS)
3. Luxembourg			✓	Voluntary Euthanasia (VE)
4. Victoria, Australia			✓	Voluntary Assisted Dying (VAD)[40]
5. Western Australia, Australia			✓	Voluntary Assisted Dying (VAD)[41]
6. Canada			✓	Medical Assistance in Dying (MAiD)
7. Quebec, Canada	✓			Medical Aid in Dying (MAiD)
8. Oregon, USA		✓		Physician-Assisted Dying (PAD)
9. Washington, USA		✓		Physician-Assisted Dying (PAD)
10. Vermont, USA		✓		Physician-Assisted Dying (PAD)
11. California, USA		✓✓		Physician-Assisted Dying (PAD)
12. Washington DC, USA		✓		Physician-Assisted Dying (PAD)
13. Hawaii, USA		✓		Physician-Assisted Dying (PAD)
14. New Jersey, USA		✓		Physician-Assisted Dying (PAD)
15. Maine, USA		✓		Physician-Assisted Dying (PAD)
16. Colorado, USA		✓		Physician-Assisted Dying (PAD)

[39] It is important to note that the legislation permitting voluntary euthanasia in Belgium does not formally apply to assisted suicide and the status of this procedure is legally uncertain. However, according to the Federal Evaluation and Control Commission — the body responsible for review compliance and monitoring of voluntary euthanasia in Belgium — assisted suicide is considered definitionally the same as voluntary euthanasia, and therefore subject to the same legal requirements: see Herman Nys, 'A Discussion of the Legal Rules on Euthanasia in Belgium Briefly Compared with the Rules in Luxembourg and the Netherlands in David Albert Jones, Chris Gastmans and Calum Mackellar (eds), *Euthanasia and Assisted Suicide: Lessons from Belgium* (Cambridge University Press, 2017) 4.

[40] The procedure regarding form of administration of VAD is unique in Victoria. Both practices are permitted under the *VAD Act 2017* (Vic). However, this is the only jurisdiction where patient administered voluntary assisted dying is the first line of preference and the physician can only administer if the patient is incapable of doing so themselves.

[41] The position regarding form of administration in Western Australia is similar to the position adopted in Victoria. However, in Western Australia, practitioner administration is not as restricted. In Western Australia, both practices are permitted under the *VAD Act* (WA). The coordinating practitioner can administer if they advise the patient that self-administration is inappropriate because the patient cannot self-administer, or the patient has concerns about self-administration or the method of administering that is suitable for the patient: see *VAD Act* (WA) s 56(2)(a)-(c).

Drawing a clear line: Distinguishing voluntary assisted dying from lawful end-of-life practices in South Australia

[2.90] The line between voluntary assisted dying ('VAD') and other associated practices is sometimes blurred as the distinguishing features are not always overt. Until the *VAD Act (SA)* comes into force, VAD remains illegal in South Australia and any medical practitioner who intentionally ends the life of a patient, even on compassionate grounds, is liable to be prosecuted.[42] VAD often comes under a distinct area of health or medical law known as 'end-of-life law'. It is, therefore, appropriate for VAD to be discussed as part of end-of-life law here. The favoured position in South Australia as reflected in the different proposed bills has been that VAD was only intended to be accessed by people suffering from a life-limiting illness; that is, individuals at the end of life. However, it is important to note that while VAD is recognised as an end-of-life practice, it does not fall within the ambit of palliative care, which is expressly stated in the *VAD Act* (SA),[43] therefore, VAD occupies a unique position on the spectrum of end-of-life treatments in South Australia.

The lawful end-of-life practices discussed below are only engaged at the end of life, with the exception of the right to refuse medical treatment, which has broader application.[44] The lawful practices considered are:

- Non-application or discontinuance of life-sustaining measures;
- Doctrine of double effect; and
- Right to refuse life-saving medical treatment.

[42] See *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 18; *Criminal Law Consolidation Act 1935* (SA) ss 11, 13, 13A ('*Consent Act*').
[43] However, the *VAD Act* (SA) was very clear and explicitly excluded VAD as a form of palliative care: see s 5; see also 'Australia and New Zealand Society of Palliative Medicine Position Statement: The Practice of Euthanasia and Physician-Assisted Suicide' *Australia and New Zealand Society of Palliative Medicine* (Web Page, November 2021) [1]-[7] < https://www.anzspm.org.au/c/anzspm?a=da&did=1025365>.
[44] See, eg, *H Ltd v J* [2010] SASC 176.

Each of these practices will be discussed in turn with reference to existing law in South Australia. This discussion will be brief, as the focus here is to highlight the fundamental distinguishing features and not provide a thorough overview of these practices.

Non-application or discontinuance of life-sustaining measures under the *Consent to Medical Treatment and Palliative Care Act 1995* (SA)

[2.100] The Parliament of South Australia clarified its position on non-application or discontinuance of life-sustaining measures in 1995 by enacting the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) ('*Consent Act*').[45] The *Consent Act* clearly establishes the parameters of lawful conduct by clarifying when a medical practitioner may lawfully discontinue or withhold medical treatment.[46] A medical practitioner who is responsible for the care of a patient in the 'terminal phase of a terminal illness'

> is under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state (whether or not the patient or the patient's representative has requested that such measures be used or continued); and must, if the patient or the patient's representative so directs, withdraw life sustaining measures from the patient.[47]

To avoid potential definitional ambiguity, the terms 'terminal phase,' 'terminal illness' and 'life sustaining measures' are all defined. These definitions are essential to understanding the situations when s 17(2) becomes operational. 'Terminal phase' is defined as being 'the phase of the illness reached where there is no prospect of recovery or remission of symptoms[48], and 'terminal illness' as 'an illness or condition that is likely to result in

[45] This practice is also known as 'withholding and withdrawing life-sustaining medical treatment'. However, the terminology used in the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) ('*Consent Act*') will be adopted.
[46] For discussion at common law concerning the difference between actively ending life and non-application or discontinuance of medical treatment, see *Airedale NHS Trust v Bland* [1993] AC 789, 11-13 (Lord Goff).
[47] *Consent Act* s 17(2).
[48] Ibid s 4(1) (Definition of 'terminal phase').

death'.[49] Finally, 'life-sustaining measures' means 'medical treatment that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation'.[50] Therefore, the non-application and discontinuance of life-sustaining measures is only permissible for persons at the end stage of a terminal illness and not before. Being afflicted with a terminal illness alone is insufficient to engage this legislative provision.

Despite its age, to date s 17(2) of the *Consent Act* has not been judicially considered in South Australia; therefore, further discussion on the scope of the provision is not possible. However, it is important to highlight that the *Consent Act* clearly clarifies s 17(2) as distinct from actively causing death (ie VAD) by explicitly providing that the *Consent Act* does not legalise medical treatment that is administered for the purpose of causing death.[51] Therefore, although the medical treatment, or lack thereof in this circumstance, may actually result in the patient's death, this practice is distinct from VAD and permitted in South Australia under existing law.[52]

Doctrine of double effect

[2.200] The doctrine of double effect ('DDE') bears a close resemblance to VAD. Although the distinction between VAD and double effect is slight, the fundamental lawful distinction lies in the underling intention.[53] Symons remarks that there are many formulations of the

[49] Ibid.
[50] Ibid s 4(1) (Definition of 'life-sustaining measures').
[51] Ibid s 18.
[52] Furthermore, the non-application or discontinuance of life-sustaining measures does not constitute an intervening cause of death: see Ibid s 17(3)(b). Instead, the cause of death is the person's underlying illness or condition.
[53] For discussion on the doctrine of double effect in Australia, see Queensland University of Technology, 'Palliative Medication', *End of Life Law in Australia* (Web Page, 10 April 2020) <https://end-of-life.qut.edu.au/palliative-care#547403>; see also White, Wilmott and Ashby (n 13) 490.

DDE, however, observes that 'the [DDE] states that, where certain criteria are met, a person acts ethically when acting to bring about a good or morally neutral effect, even if her action also has certain foreseen, though not intended or desired, bad effects.'[54] This definition, as it applies in end-of-life care, will be considered further below.

Unlike VAD, the doctrine of double effect is lawful in South Australia and well-accepted as part of palliative care practice.[55] The rule initially existed at common law, but South Australia has also clarified the doctrine of double effect in the *Consent Act*.[56] There has, however, been speculation concerning whether the legislative rule superseded the position at common law, or if they indeed exist concurrently.[57] To date, there has been no judicial consideration on this point; therefore, this matter remains unresolved. An important point of distinction is that, at common law, the patient need not consent to the treatment; however, under the *Consent Act*, consent must be explicitly given.[58] Both the

[54] Xavier Symons, 'Does the Doctrine of Double Effect Apply to the Prescription of Barbiturates? *Syme v the Medical Board of Australia*' (2018) 44(4) *Journal of Medical Ethics* 266, 266; see also, Xavier Symons, 'Strengthening the Ethical Distinction Between Euthanasia, Palliative Opioid Use and Palliative Sedation, (2020) 46(1) *Journal of Medical Ethics* 57, 57.

[55] For recent discussion on the regulation of palliative care practices at the end of life, see Lindy Willmott, Ben White, Donella Piper, Patsy Yeates, Geoffrey Mitchell and David Currow, 'Providing Palliative Care at the End of Life: Should Health Professionals Fear Regulation?' (2018) 26(1) *Journal of Law and Medicine* 214; see also Steven Trankle, 'Decisions that Hasten Death: Double effect and the Experiences of Physicians in Australia' (2014) 15(1) *BMC Medical Ethics* 26. Although this is beyond the scope of this discussion, for consideration of the doctrine of double effect and the withdrawal or withholding of medical treatment in relation to infants and children, see *Re Baby D* [2011] FamCA 176 [82]-[83], [94]-[98], [138]-[139], [155], [227]-[228] (Young J);

[56] See **[2.300]** below.

[57] See White, Wilmott and Ashby (n 13).

[58] Ibid 490; *Consent Act* s 17(1). It is important to note that different palliative care practices are supported by the doctrine of double effect and are currently lawful in South Australia. Such practices include palliative sedation therapy ('PST') and appropriately titrated administration of opioids ('ATAO'). The requirements concerning eligibility for TPS or ATAO is established by the common law and legislation discussed in **[2.200]** and informed by clinical guidelines. Detailed discussion of these practices is beyond the scope of this thesis. See, eg, Xavier Symons, 'Strengthening the Ethical Distinction Between Euthanasia, Palliative Opioid Use and Palliative Sedation, (2020) 46(1) *Journal of Medical Ethics* 57; Merlina Sulistio, Robert Wojnar and Natasha Michael, 'Propofol for Palliative Sedation' (2020) 10(4-6) *Supportive and Palliative Care* 3; Nathan Cherny and Lukas Radbruch, 'European Association for Palliative Care (EAPC) Recommended Framework for the use of Sedation in Palliative Care' (2009) 23(7) *Palliative Medicine* 581; 'Palliative Sedation Therapy: Guidance Document', *Australia and New Zealand Society of Palliative Medicine* (Web Page, 2017) < https://www.anzspm.org.au/c/anzspm?a=sp&pid=1618280700>; Charles Douglas, Ian Kerridge and Rachel Ankeny, 'Narratives of 'Terminal Sedation', and the Importance of the Intention-Foresight Distinction in Palliative Care Practice' (2011) 27(1) *Bioethics* 1; Chirag Patel et al, 'Palliative

position at common law and the rule under the *Consent Act* will be discussed in the next section.

The rule at common law

[2.300] *R v Adams* ('*Adams*')[59] was the first known case to recognise at common law what is now known as the doctrine of double effect. In *Adams*, it was determined that if a medical practitioner administers medication to a dying person to relieve pain and distress but incidentally shortens that person's life, they will not be criminally liable for murder. In his judgment, Devlin J articulated the parameters of this rule, observing that

> [i]f the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he has taken incidentally shorten life … but … no doctor, nor any man, no more in the case of the dying than of the healthy, has the right to deliberately cut the thread of life.[60]

Thus, central to the doctrine of double effect is intent, which must always be to relieve pain and *not* to intentionally hasten death. White, Wilmott and Ashby distil the philosophical underpinning of the doctrine of double effect, explaining that 'an act performed with good intent can still be moral despite its negative consequences',[61] which in this circumstance is characterised by the underlying intention of the medical practitioner — to relieve pain and incidentally, not intentionally, shorten life.[62] However, South Australia is one of four jurisdictions in Australia that has clarified this rule legislatively.

Sedation: A Safety Net for the Relief of Refractory and Intolerable Symptoms at the End on Life' (2019) 48(12) *Australasian Journal of General Practice* 838.

[59] (Unreported, Central Criminal Court, Devlin J, 8 April 1957) (*'Adams'*), cited in White, Wilmott and Ashby (n 13), 486.

[60] Ibid; see also *R v Cox* (Winchester Crown Court, 18 September 1992).

[61] White, Wilmott and Ashby (n 13) 486.

[62] For recent discussion on the (mis)use of the doctrine of double effect in VAD see Symons (n 54).

The rule under the *Consent to Medical Treatment and Palliative Care Act 1995* (SA)

[2.400] The position under the *Consent Act* differs slightly to the rule at common law. Some scholars contend that the provisions in the *Consent Act* are more stringent that the common law rule as there is the requirement to act commensurate with accepted principles of palliative care practice.[63] The relevant provision of the *Consent Act* indemnifies medical practitioners from civil and criminal liability if they incidentally hasten a person's death in the course of providing treatment to relieve pain and distress. However, to come under the protective ambit of s 17(1), several conditions must be satisfied. These conditions are that the person must be in the *terminal phase of a terminal illness* and the medical practitioner must administer the treatment '(a) with the consent of the patient or the patient's representative; and (b) in good faith and without negligence; and (c) in accordance with proper professional standards of palliative care'.[64] Therefore, it is evident that the legislature have clearly established the requirements to satisfy the defence of double effect.

Thus, as can be seen, the underlying principle of the doctrine of double effect at common law and under the *Consent Act* are the same, although key differences are evident. Neither the common law rule nor the provision in the *Consent Act* have been judicially considered in South Australia, therefore further discussion of the breadth of these principles is not possible. However, it is evident though that these practices are narrow in their application as they are limited to people very close to death.

Right to refuse medical treatment

[63] Ibid.
[64] *Consent Act* (SA) s 17(1).

[2.500] The right to refuse medical treatment is well protected at common law. It is, however, broader in scope than the other practices discussed here, as this right can generally be exercised by any person over the age of 16 with capacity in South Australia, irrespective of whether they are at the end of their life or not.[65] However, outlining the parameters of this rule remains essential to this discussion, as it too is a well-accepted part of end-of-life law and practice.

The common law right to refuse medical treatment is clear in South Australia.[66] It is widely accepted that capable persons above the age of 16 have the right to refuse medical treatment,[67] even if doing so would result in their death.[68] This right 'exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent'.[69] Relevant factors here are that the patient must be capable of giving consent and are acting voluntarily.[70] In *Brightwater Care Group (Inc) v Rossiter,*[71] Martin CJ provided an overview of this fundamental right, explaining that

> another principle well established at common law is the principle which has been described in the cases as the right of autonomy or self-determination. Lord Hoffmann has described this right as being related to respect for the individual human being and in particular for his or her right to

[65] Ibid s 6.
[66] See *H Ltd v J* [2010] SASC 176 ('*H Ltd*').
[67] The age of valid consent to medical treatment, including refusal of consent, in South Australia is 16 years of age: see *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6. This rule is unique to South Australia, as refusal of life-saving medical treatment in other jurisdictions differs. For an overview of the rules regarding capacity throughout Australia's States and Territories: see Queensland University of Technology, 'Capacity and Consent to Medical Treatment' *End of Life Law in Australia* (Web Page, 18 December 2020) <https://end-of-life.qut.edu.au/capacity>.
[68] This includes artificial hydration and nutrition: see *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 ('*Brightwater*'); for judicial consideration on the duty of aged care facilities to provide nutrition, hydration and insulin to a patient against their express refusal, see *H Ltd*.
[69] *Re T (Adult Refusal of Medical Treatment*) [1993] C.A. Fam. 95, 113 (Lord Donaldson M.R.) ('*Re T*'); this principle has been affirmed in *Hunter and New England Health Service v A* (2009) 74 NSWLR 88; *Re JS* [2014] NSWSC 302 [7]-[8] (Darke J).
[70] Acting voluntarily is a critical component of a voluntary decision in consent to medical treatment. Factors that can vitiate voluntariness are coercion and undue influence. For judicial consideration of undue influence and refusal of medical treatment factors that can vitiate a consent, see *Re T*, 112; See, eg, *Re JS* [2014] NSWSC 302 [31] (Darke J); *H Ltd*.
[71] [2009] WASC 229.

> choose how he or she should live his or her life. Included within the right of autonomy or self-determination is the right, described as long ago as 1914 in the United States by Justice Cardozo, as the right of 'every human being of adult years and sound mind ... to determine what shall be done with his own body. The corollary of that requirement is that an individual of full capacity is not obliged to give consent to medical treatment, nor is a medical practitioner or other service provider under any obligation to provide such treatment without consent, even if the failure to treat will result in the loss of the patient's life. That principle has been established by decisions in each of the major common law jurisdictions, including the United States.[72]

Refusal of medical treatment for end-of-life patients is not limited to administration of pharmacological substances and other forms of medical interventions but also extends to the right to refuse food and water; a practice known by the acronym VSED (voluntary stopping of eating and drinking) ('VSED').[73] VSED falls within the ambit of accepted palliative care practice for end-of-life patients which is characterised by the voluntary stopping of eating and drinking by a person who has capacity to consent.[74] The legality of VSED in South Australia was affirmed in *H Ltd v J,*[75] where Kourakis J (as he then was) of the Supreme Court of South Australia held that the operator of an aged care facility in which J – the first defendant – resided could lawfully adhere to J's decision to refuse food and water, providing that J had capacity when the decision was made. Kourakis J carefully articulated the legal obligations of aged care facilities towards their residents – characterised as a 'relationship of dependency' – and the rights of residents to make decisions pertaining to their healthcare, explaining that

> Generally, a person will not be liable to provide the necessary sustenance where the person whom he or she is otherwise liable to sustain withholds the mutual co-operation which is necessary to discharge the liability. However, the duty on which s 30 of the CLCA [*Criminal Law Consolidation Act 1935* (SA)] operates arises from a relationship of dependency in which the protected person is in a vulnerable position [and] the duty may be breached where … the protected person who has

[72] *Brightwater*, 24–5 (citations omitted); Kourakis CJ in *H Ltd* also accepted Martin's CJ statement of principles see [35]–[36].
[73] See Jocelyn Downie, 'An Alternative to Medical Assistance in Dying? The Legal Status of Voluntary Stopping Eating a Drinking' (2018) 1(2) *Canadian Journal of Bioethics* 48.
[74] Phillipa Trowse, 'Voluntary Stopping of Eating and Drinking in Advance Directives for Adults with late-Stage Dementia' (2020) 39(2) *Australasian Journal on Ageing* 142, 143.
[75] [2010] SASC 176.

> refused food is not in a position to make a rational decision. In such circumstances it may be necessary for the person who is liable to provide the necessities referred to in the section to take at least some steps to provide them notwithstanding their refusal.[76]

In this circumstance, Kourakis J found that J had decision-making capacity,[77] thus she could lawfully direct the nursing home to comply with her refusal.[78] VSED falls under the category of the right to refuse medical treatment. However, it is important to note that while VSED is an accepted palliative care treatment, it is not limited to end-of-life situations and has broader application, applying generally to adults with decision-making capacity. The parameters and potential ethical considerations that VSED may invoke will not be discussed further. It is lawful in South Australia, is not VAD and remains an accepted part of end-of-life care.

As can be seen, the right to refuse medical treatment is a firmly entrenched principle and any conflict that arises between the right of the State to preserve life and the right of the individual to make choices about it has been resolved in favour of individual autonomy and self-determination.[79] Therefore, refusal of medical treatment is not VAD and a medical practitioner does not commit an indictable offence if they accede to a competent adult's refusal of medical treatment,[80] even if the refusal would cause death.

Summary of lawful end-of-life practices in South Australia

[2.600] South Australia currently permits several key end-of-life practices, which are governed by both legislation and common law. For ease of reference, an overview of these

[76] Ibid [78].
[77] Ibid [46].
[78] Ibid [98].
[79] See *Hunter and New England Area Health Service v A* [2009] NSWCA 761, 36.
[80] See also *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290.

practices and their legality is provided in Table 2 below. Although the end-of-life practices discussed in this chapter can still result in the patient's death, by act or omission, they are lawful and must not be confused with VAD. Therefore, a key distinction between these existing practices and VAD is that under existing law (excluding the *VAD Act* (SA)), a medical practitioner cannot, under any circumstances, administer, either directly or by providing access to, lethal medications with the intention to end a person's life.

Existing lawful end-of-life practices in South Australia will not be subject to further consideration. These practices fall outside the scope of this discussion and serves merely as essential background information of the focus of this thesis, which is the adequacy of undue influence as a safeguard in proposed VAD legislation. South Australia has a detailed history of attempted law reform in this area and this discussion will now turn to an examination of this history where the legislative response to safeguarding against undue influence will be analysed.

Table 2 – Overview of lawful and unlawful end of life practices in South Australia

Practice	Lawful	Unlawful	Relevant Law
1. Voluntary Assisted Dying[81]		✓	1. *Criminal Law Consolidation Act 1935* (SA) ss 11, 13, 13A[82]
2. Non-application or discontinuance of life sustaining measures	✓		1. *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(2)
3. Doctrine of double effect	✓		1. *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(1) 2. *R v Adams* (Central Criminal Court of London, 9 April 1957) 3. *R v Cox* (Winchester Crown Court, 12 September 1992)
4. Right of competent adult to refuse medical treatment, including VSED	✓		1. *Brightwater Care Group v Rossiter* [2009] 40 WAR 84 2. *H Ltd v J* (2010) 107 SASR 176

[81] Defined to include both practitioner administration and self-administration of the lethal medication.
[82] Despite the passing of the *VAD Act* (SA), VAD remains unlawful until the Act comes into force.

Chapter 3: History of failed attempts to legalise voluntary assisted dying in South Australia

Introduction

[3.10] Since 1995, the South Australian legislature have rigorously debated VAD. The bills tabled were diverse regarding eligibility criteria and procedural and substantive safeguards. However, one consistent key feature was that the legislature intended a request for VAD to be voluntary, and several protections were built in to the proposed legislative framework aiming to meet this end. Undue influence was one of these key protections, yet it did not arise as a safeguard for a voluntary decision until 2010 when it made its first appearance in the Consent to Medical Treatment and Palliative Care Act (End of Life Arrangements) Amendment Bill 2010 (SA). Since its introduction into the proposed legislative framework, undue influence has not been subject to critical analysis by the legislature concerning its appropriateness as a safeguard in this context, nor how it will heighten protection of a voluntary decision. This will be addressed in detail in Chapter 5.

Attempted VAD reform in South Australia: An ongoing issue before parliament

[3.20] The South Australian legislature has been extremely active in attempts to legalise VAD since 1995.[1] On 20 March 2019, the debate in South Australia was reignited when Kyam Maher (Leader of the Opposition) moved to have a joint committee established to look into

> the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they manage their end of life when experiencing chronic and/or terminal illnesses, including the role of palliative care; (b) the current legal framework, relevant reports and materials in other Australian states and territories and

[1] An overview of the bills is provided in Table 3.

> overseas jurisdictions, including the Victorian and Western Australian parliamentary inquiries into end-of-life choices, Victoria's Voluntary Assisted Dying Act 2017 and implementation of the associated reforms; (c) what legislative changes may be required, including an examination of any federal laws that may impact such legislation; and any other related matter.[2]

This represented a new approach to an ongoing question, as the establishment of a joint committee to look into end-of-life options has not been the preferred method to initiate law reform in this area. The last committee on VAD was convened in 1996, which determined by a 4:2 split (the Honourable Dr Bob Such and Sandra Kanck MLC dissenting) that VAD should remain criminal offences.[3] Central to this finding was that the majority 'believed the *Consent to Medical Treatment and Palliative Care Act 1995* not only covered most people's needs, but that South Australia was at the forefront of legislation in this area'.[4] This may have been true at that time; however, the landscape concerning VAD has changed considerably over the past 20 years with many jurisdictions, both nationally and internationally, implementing VAD legislation,[5] which likely reflects a significant shift in public sentiment on the issue.

The South Australian Joint Committee ('SAJC'), convened in 2020, tabled its report on 13 October 2020.[6] The terms of reference of the SAJC were broad, inviting submissions on, inter alia, South Australia's existing legal framework concerning end-of-life practices, approaches to VAD in other jurisdictions,[7] and what legislative changes would be required

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[2] South Australia, *Hansard*, Legislative Council, 20 March 2019, 2933 (Kyam Maher, Leader of the Opposition).
[3] Social Development Committee, *Inquiry into the Voluntary Euthanasia Bill 1996*, Parliament of South Australia, No 12 of 1999, 20 October 1999, xiv ('SDC Report').
[4] Ibid. Since the *Consent to Medical Treatment and Palliative Care Act* 1995 (SA) ('*Consent* Act') came into force, it remains largely unchanged, with minimal amendments being passed despite the shifts in societal attitudes towards VAD and other areas of healthcare.
[5] The international landscape concerning VAD is considered in detail in Part 2.
[6] Joint Committee on End of Life Choices, *Report of the Joint Committee on End of Life Choices*, Parliament of South Australia, 13 October 2020 ('JC ELC').
[7] Some issues of importance before the South Australian Joint Committee on End of Life Choices were recent developments that have occurred in Australia: see, eg, the *Voluntary Assisted Dying Act 2017* (Vic) ('*VAD Act* (Vic)') which came into force on 19 June 2019; Legislative Council Legal and Social Services

in South Australia to regulate and control the provision of VAD. The SAJC avoided adopting a particular stance toward legalisation of VAD in South Australia, instead adopting a holistic approach toward existing and unlawful (ie VAD) end-of-life practices. It was recognised that whilst 'there are sincere, genuine and deeply held divergent views' concerning VAD, 'the most relevant approach [for legalisation] with the highest level of safeguards, checks and balances while allowing this end of life choice appears to be Victoria'.[8] However, the *VAD Act* (Vic) was not accepted without criticism and was chastised on the grounds that it was too restrictive and created barriers to access VAD.[9] In response to this, the SAJC observed that

> Western Australia has introduced a system of for [VAD] that provides greater flexibility for people in regional and remote areas noting that South Australia is more affected by geographic dispersion of population than Victoria but less than Western Australia.[10]

Committee, *Inquiry into End of Life Choices*, Parliament of Victoria (Report No 174, June 2016) ('*Inquiry into ELC* (Vic)'); the *Voluntary Assisted Dying Act 2019* (WA) ('*VAD Act* (WA)') which became operational on 1 July 2021; Government of Western Australia, Voluntary Assisted Dying, *Department of Health* (11 December 2019) <https://ww2.health.wa.gov.au/voluntaryassisteddying>; Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (Report 1, August 2018); 'Western Australian Government Response Joint Select Committee on End-of-Life Choices Report My Life, My Choice', *Government of Western Australia* (Web Page) <https://ww2.health.wa.gov.au/Articles/J_M/Joint-Select-Committee-on-End-of-Life-Choices-Report-My-Life-My-Choice>; Ministerial Expert Panel on Voluntary Assisted Dying Final Report, *Government of Western Australia* (Web Page, June 2019) <https://ww2.health.wa.gov.au/Reports-and-publications/Voluntary-assisted-dying-final-report>. Furthermore, in March 2020, the Queensland Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee tabled their report in parliament on VAD: see Health, Communities, Disability Services and Domestic Violence and Family Violence Prevention Committee, Parliament of Queensland, *Voluntary Assisted Dying* (Report No. 34, March 2020) viii. ('VAD Report (Qld)'). This is a significant development for Queensland, as this is the first time this jurisdiction has ever established a parliamentary committee to inquire into VAD. Additionally, Queensland remains the only jurisdiction in Australia never to have introduced a VAD bill in their State Parliament. The Committee put forward 21 recommendations, the first stating that 'the Queensland Government use the well-considered draft legislation submitted to the inquiry by Professors Lindy Willmott and Ben White as the basis for a legislative scheme for voluntary assisted dying': VAD Report (Qld) x. Finally, although, New Zealand is not an Australian jurisdiction, it passed the *End of Life Choices Act 2019* (NZ). However, a peculiar feature of this Act is that it will only come into force 'if a majority of electors voting in a referendum respond to the question … supporting this Act coming into force': *End of Life Choices Act 2019* (NZ) s 2(1). The federal election was held on 17 October 2020 and the Act passed with overwhelming support: see Michael Cook, 'New Zealand will soon have Legal Voluntary Euthanasia' *BioEdge* (31 October 2020) <https://www.bioedge.org/bioethics/new-zealand-will-soon-have-legal-voluntary-euthanasia/13601>. For further discussion on legal attempts to legalise VAS in New Zealand, see Rex Tauati Adhar, 'The Case Against Euthanasia and Assisted Suicide' (2016) 3 *New Zealand Law Review* 459; see also Health, Communities, Disability Services and Domestic Violence and Family Violence Prevention Committee, Parliament of Queensland, *Voluntary Assisted Dying* (Report No. 34, March 2020) 27.

[8] JC ELC (n 6) 6.

[9] See especially ibid 36-41.

[10] Ibid 6.

Therefore, the SAJC recognised both the strengths and limitations with Victoria and Western Australia's respective VAD legislation in relation to how they would impact the different demographic environment of South Australia, suggesting that a hybrid model to meets the needs of South Australia would be preferred. Identical VAD bills were introduced into the Legislative Council and the House of Assembly in South Australia on 2 December 2020[11] and, as considered at [1.50] above, the bill tabled in the Legislative Council was passed on 24 June 2021.

Overview of VAD bills in South Australia: 1995–2016

[3.30] Twenty-three VAD bills have been tabled in South Australian Parliament since 1995.[12] Points of distinction have concerned eligibility criteria and the substantive and procedural safeguards, including safeguards that had the primary purpose of protecting voluntary decision-making. Defining who would be eligible to make a request for VAD was often a contentious issue before parliament, especially regarding the bills that sought to broaden access to VAD, as opposed to restrict it to persons with end-stage terminal illness as prescribed in Victoria and Western Australia.[13] Notwithstanding this controversy, many bills remained unchanged and were simply reintroduced into parliament as a lapsed bill. In summary:

- 18 bills sought to create a stand-alone legislative framework to control the provision of VAD
- 1 bill sought to legalise VAD by referendum

[11] The Voluntary Assisted Dying Bill 2020 (SA) ('VAD Bill (SA)') was tabled in the Legislative Council by Dr Susan Close, Deputy Leader of the Opposition, and the VAD Bill (SA) was tabled in the House of Assembly by Kyam Maher on 2 December 2020.
[12] See Table 3 for list of bills.
[13] *VAD Act* (Vic) s 9; *VAD Act* (WA) s 16.

- 1 bill sought to amend the *Criminal Law Consolidation Act* 1935 (SA) by providing a medical defence for medical practitioners charged with murder or aiding, abetting, counselling suicide, or an attempt as the case may be
- 3 bills sought to incorporate VAD into existing end-of-life care practice by inserting provisions for VAD into the existing *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

It is evident that the majority of bills sought to regulate the provision of VAD through an independent legislative framework. This is consistent with the approach adopted in most overseas jurisdictions, where the substantive and procedural safeguards have been articulated through an independent legislative instrument.[14] Of the South Australian bills, 16 originated in the House of Assembly and 7 originated the Legislative Council. However, only 7 of the 23 bills actually made it to a second or third reading vote, as the majority (15) lapsed due to prorogation.[15] For ease of reference, Table 3, located at the close of this chapter, provides an overview of all VAD bills before parliament. Another important point regarding the outcome of the bills listed in Table 3 is that, of the 7 bills that did progress to a vote, over time there appears to be a marginal shift in support for VAD.

[14] See Part 2 for discussion on VAD in other jurisdictions. It is important to note that of all the bills tabled in parliament, the bills that sought to align VAD with existing palliative care practices under the *Consent to medical Treatment and Palliative Care Act 1995* (SA) were highly controversial. For example, in the second reading speech for the Consent to Medical Treatment and Palliative (Voluntary Euthanasia) Amendment Bill 2008 (SA), The Hon. Carmel Zollo focussed on the inconsistencies with the bill and the existing lawful palliative care practice, remarking that 'I am of the view that this bill does not limit the application of the voluntary active euthanasia to the terminally ill and that the Hon. Mark Parnell's bill casts a very wide net indeed … the palliative care act deals with consent to medical treatment and regulates medical practice so far as if affects the care of people who are dying … I am in agreement … that the two — that is, palliative care and voluntary active euthanasia—are distinctly different actions with different intentions': see South Australia, *Hansard*, Legislative Council, 28 October 2008, 3689, 3769 (Carmel Zollo). Carmel Zollo also raised similar concerns with the subsequent Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Bill 2010 (SA): see South Australia, *Hansard*, Legislative Council, 24 November 2010, 1593, 1701. This perceived inconsistency was not remedied in Mark Parnell's subsequent Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Bill 2010 (SA), although the change in title (erroneously) alludes that eligibility was restricted to persons at the end of life: see South Australia, *Hansard*, Legislative Council, 29 September 2010, 943, 963 (Mark Parnell).

[15] One bill was withdrawn from the House of Assembly, and one bill was discharged: see Table 3.

Broadening end-of-life options for terminally ill persons in South Australia: The Voluntary Euthanasia Bill 1995 (SA)

[3.40] The Voluntary Euthanasia Bill 1995 (SA) ('VE Bill') was introduced by independent MP John Quirke in 1995. The VE Bill sought to establish a framework for adults in the terminal phase of a terminal illness to request VAD, subject to safeguards. A person was considered to be in the terminal phase of a terminal illness when their underlying condition would have caused death within 12 months.[16] This restriction intended to limit access to VAD to ensure that this truly remained an end-of-life option that could not be exercised by persons with potentially years to live.[17] Of significance to the central issue considered in this thesis was that undue influence was not explicitly safeguarded against. Instead, the approach taken by the legislature was to safeguard against duress only, which is, as considered in Part 3, distinct from undue influence, although both doctrines can equally vitiate a valid consent.[18]

In his second reading speech, Mr Quirke indicated that the primary motivation of the VE Bill was to provide a free choice for 'terminally ill [persons] to bravely, quickly and, with as much dignity as possible, pass out of this world'.[19] Much of his second reading speech focused on freedom of choice, which he opined existing law in South Australia curtailed.

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[16] An overview of the eligibility requirements, safeguards and outcome is provided in Table 3 and Table 4.
[17] The requirement that death occur within a prescribed time period is not an uncommon feature of current VAD legislation. For example, the *VAD Act* (Vic) prescribes that death must be expected to occur within weeks or months, but not exceeding six months, for an incurable disease, illness or medical condition. However, if the person is diagnosed with a neurodegenerative disease, illness or medical condition, expected occurrence of death is increased to 12 months: see ss 9(1)(d)(iii), 9(4).
[18] Additionally, there was no explicit requirement for the medical practitioner to assess for elements of duress. Instead, this obligation was deferred to witnesses who had to attest that the person requesting euthanasia 'was not apparently acting under duress': see Voluntary Euthanasia Bill 1995 (SA) s 7(2)(c). However, existing legal principles for a valid consent would still apply; therefore, a medical practitioner would still be required to assess for elements of unlawful external pressure in a request.
[19] South Australia, *Hansard*, House of Assembly, 9 March 1995, 1864 (John Quirke); see also South Australia, *Hansard*, House of Assembly, 6 April 1995, 2206 (Murray De Laine).

The VE Bill, however, encountered strong opposition in the House of Assembly. A primary driver of this opposition was that the Consent to Medical Treatment and Palliative Care Bill 1995 (SA) ('Consent Bill') was soon to become law in South Australia.

The Consent Bill provided much needed clarification and guidance for doctors and the public concerning the parameters of lawful end-of-life medical practices in South Australia. Support for the Consent Bill was preferred over a VAD option,[20] as the common law doctrine of double effect was clarified and provided doctors with immunity from liability if they incidentally hastened the death of a terminal patient. Importantly, the Consent Bill (s 17 in particular) did not legalise the *intentional* taking of life, which the VE Bill aimed to do. Under the Consent Bill, medical treatment administered to intentionally cause death was unlawful,[21] thus, reflecting a strong anti-VAD sentiment, indicative of parliament's strong position towards medical acts that had the primary intention of ending life.

Additional arguments raised in opposition to the VE Bill were that the right to refuse medical treatment and end-of-life and palliative care options available in South Australia were sufficient treatment options but remained largely misunderstood by society. Educating the public on their right to refuse medical treatment and other end-of-life options available was viewed as preferable over the legalisation of VAD.[22] Finally, it was argued that if VAD were permitted it would, over time, inevitably lead to involuntary euthanasia, viewed as a consequence of an internalised lack of respect for all diverse

[20] See, eg, South Australia, *Hansard*, House of Assembly, 20 July 1995, 2869 (Kent Andrew); South Australia, *Hansard*, House of Assembly, 16 March 1995, 1989-90 (Mick Atkinson).
[21] *Consent Act* s 18.
[22] See Atkinson (n 20) 1989-91; see Andrew (n 20); see also South Australia, *Hansard*, House of Assembly, 20 July 1995, 2629–2630 (Steve Condous); South Australia, *Hansard*, House of Assembly, 20 July 1995, 2868 (Joan Hall); South Australia, *Hansard*, House of Assembly, 20 July 1995, 2870 (Liz Penfold).

forms of human life,[23] largely reminiscent of Nazi Germany's euthanasia program (*Krakkenmorde Aktion T4*).[24] Despite this staunch opposition, this VE Bill represents the first crucial step in the VAD journey in South Australia, as it initiated discussions on broadening end-of-life options and sought to empower patients as decisions-makers and narrators of their life. However, the VE Bill was zealously defeated in the House of Assembly.[25] However, this did little to quell the euthanasia debate in South Australia. The following year saw the introduction of two VAD bills into the Legislative Council.[26] On the 25 March 1998, the Voluntary Euthanasia Bill 1996 (SA) was referred to the Social

[23] See Atkinson (n 20) 1990; South Australia, *Hansard,* Legislative Council, 12 November 2008, 633 (Mark Parnell); South Australia, *Hansard*, House of Assembly, 16 March 1995, 1990 (Mick Atkinson); South Australia, *Hansard*, House of Assembly, 16 March 1995, 1992 (Joe Scalzi); South Australia *Hansard*, House of Assembly, 23 March 1995, 2120-21 (Stewart Leggett). A similar argument has been raised concerning the increased number of individuals requesting euthanasia in the Netherlands, where recent data suggests that the increase in demand for euthanasia is correlated to the normalisation of the practice. In an recent article, Professor Theo Boer, Ethicist and former long-standing member of one of five Regional Review Committees established under the *Termination of Life on Request and Assisted Suicide Act (2002)* (Nth) raised concerns about the shift in public perception on assisted dying in the Netherlands, arguing that 'although the law treats assisted dying as an exception, public opinion is beginning to interpret it as a right, with a corresponding duty for doctors to become involved in these deaths': see Debra Vermeer, 'Euthanasia has been a 'Disaster' Overseas: Experts say as new push Escalates' *The Catholic Weekly* (17 January 2017) <https://www.catholicweekly.com.au/euthanasia-has-been-a-disaster-overseas-experts-say-as-renewed-australian-push-escalates/>; Jacob Koopman, 'Further Turns in the Conception and Regulation of Physician-Assisted Dying in the Netherlands' (2019) *American Journal of Medicine* (advance); Jacob Koopman and Theo Boer, 'Turning Points in the Conception and Regulation of Physician-assisted Dying in the Netherlands' (2016) 129(8) *American Journal of Medicine* 773; Michael Cook, 'Demand for Euthanasia Surges in the Netherlands' *Bioedge* (11 November 2017) <http://www.bioedge.org/bioethics/demand-for-euthanasia-surges-in-the-netherlands/12508>. Similarly, in the province of Quebec Canada where MAiD has been permitted since 10 December 2015, concern has been raised over the drastically increasing numbers for MAiD. In the first period, 161 requests were reported. In the latest reporting period (5th period) this increased to 542: see Toujours Vivant, 'Third Report From Quebec's Euthanasia Commission — 142 Unaccounted Deaths' *Euthanasia Prevention Coalition* (14 December 2018) <http://alexschadenberg.blogspot.com/2018/12/third-report-from-quebecs-euthanasia.html>; see also Commission sur les soins de fin de vie, 'Rapport annuel d'activites: 1er juillet 2017 – 31 mars 2018' Government du Quebec (2018) https://www.dropbox.com/s/1mvo0pi60lyimfg/3e%20Rapport%20annuel%20de%20la%20CSFV_1er%20juillet%202017%20au%2031%20mars%202018.pdf?dl=0; Owen Dyer, 'Voluntary Euthanasia Deaths in Quebec Outstrip Predictions by Three to One' (2016) 355 *British Medical Journal*.

[24] See especially Michael Robertson, Astrid Ley and Edwina Light, *The First into the Dark: The Nazi Persecution of the Disabled* (University of Technology Sydney ePress, 2019); see also Robert Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (Macmillan, 1986).

[25] South Australia, *Hansard,* House of Assembly, 27 July 1995, 2991.

[26] South Australia, *Hansard*, Legislative Council, 6 November 1996, 341 (Anne Levy); South Australia, *Hansard*, Legislative Council, 6 November 1996, 345 (Sandra Kanck); see also Table 3.

Development Committee ('SD Committee') for broader public debate and engagement on this issue.[27]

Report of the Social Development Committee's Inquiry into the Voluntary Euthanasia Bill 1996

[3.50] The Social Development Committee's ('SDC') *Inquiry into the Voluntary Euthanasia Bill 1996* was tabled in Parliament on the 20 October 1999 and received 3,946 valid submissions, reflecting a high level of public engagement in the VAD debate.[28] Of the 3,946 submissions, 2,081 submissions (52.7%) were opposed to the legalisation of VAD and 1,848 (46.8%) were in favour of legislative reform and supported the enactment of the Voluntary Euthanasia Bill 1996 (SA).[29] It is noteworthy that the majority of supporting and opposing arguments submitted to the SDC are consistent with the arguments posited in other jurisdictions where the legalisation of euthanasia remains a topical issue.[30] This observation shows that while the pivotal arguments in the ongoing VAD debate remain largely unchanged over the past few decades, support for law reform for VAD is growing as more jurisdictions are enacting VAD legislation.

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[27] South Australia, *Hansard,* Legislative Council, 9 July 1997, 1784.

[28] This high level of public engagement is evident when compared to the number of submissions received from more recent committees established in other States to inquire into law reform for VAD. For instance, in Queensland, the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, which tabled its report in favour of VAD law reform in March 2020, received just under 5,000 submissions: see VAD Report (Qld) (n 7) viii. The Western Australian Joint Select Committee on End of Life Choices which tabled its report on VAD in August 2018 received around 700 submissions: see JSC ELC (WA) (n 7). Finally, in Victoria, the Legal and Social Issues Committee's Inquiry into End of Life Choices which tabled its report in June 2016 received 1,037 submissions: see *Inquiry into ELC* (Vic) (n 7) xix.

[29] SDC Report (n 3) iv.

[30] For examples of broader public debate and submissions on euthanasia and assisted suicide or VAD in other jurisdictions see ELC (Vic) (n 7); Joint Standing Committee on Community Development, *Report on the Dying With Dignity Bill 2009*, Parliament of Tasmania, No 36 of 2009, 2 October 2009; Health and Sports Committee, The Scottish Parliament, *Analysis of Submissions of Evidence on the Assisted Suicide (Scotland) Bill* (SP No 587, 2014); see also Ben White and Lindy Wilmott, 'How Should Australia Regulate Voluntary Euthanasia and assisted Suicide?' (2012) 20(2) *Journal of Law and Medicine* 410.

The central arguments put before the SDC were complex, diverse and largely irreconcilable. Autonomy arguments featured extensively in the submissions and were used to fuel both sides of the debate. For example, it was argued that individual autonomy exemplified as the right to choose how to live one's life should be respected.[31] Conversely, the limits of individual autonomy were highlighted and it was argued that the prevailing duty to promote the collective good in society outweighs individual autonomy.[32] Other significant arguments were the ethical and moral distinctions between killing and letting die; double effect and intention in law; and the sanctity of life and slippery slope arguments.[33] The SDC concluded, although not unanimously (4:2 split with Sandra Kanck and Bob Such dissenting), that: (1) active voluntary euthanasia and physician-assisted suicide remain criminal offences in South Australia; and (2) the Voluntary Euthanasia Bill 1996 (SA) should not be reintroduced as a lapsed Bill.[34] Regardless of this finding, South Australia continued to introduce VAD bills on almost a yearly basis, which are outlined in Table 3.

It is, therefore, evident that legalisation VAD has been a recurrent issue in South Australia for over two decades now. While attempts to legalise VAD have been repeated in this State, attempts at how best to regulate and control the provision of VAD through an Act of parliament were diverse, resulting in significant variation in many bills before parliament.

[31] SDC Report (n 3) 71-5.
[32] Ibid.
[33] Ibid 75–89.
[34] Four of the six members of the Social Development Committee were opposed to legalisation of voluntary euthanasia in South Australia: the Hon. Dr Bob Such and the Hon. Sandra Knack dissenting. In their dissenting statement, Such and Knack recommended that 'the criminal status of active voluntary euthanasia and physician-assisted suicide be removed and that these practices be regarded as the ultimate steps in palliative care': ibid xiv.

Table 3 – Outcome of Voluntary Euthanasia Bills SA 1995–2016

Title of Bill	Chamber	Outcome	Introduced By
1. Voluntary Euthanasia Bill 1995 (SA)	House of Assembly	Negative: failed Second Reading 30/12[35]	J A Quirke
2. Voluntary Euthanasia Bill 1996 (SA)	Legislative Council	Passed: Second Reading carried 13/8[36] Lapsed[37]	Anne Levy
3. Voluntary Euthanasia (Referendum) Bill 1996 (SA)	Legislative Council	Lapsed	Sandra Kanck
4. Dignity in Dying Bill 2001 (SA)	Legislative Council	Lapsed	Sandra Kanck
5. Dignity in Dying Bill 2001 (SA)	House of Assembly	Discharged	Bob Such
6. Dignity in Dying Bill 2002 (SA)	Legislative Council	Lapsed	Sandra Kanck
7. Dignity in Dying Bill 2003 (SA)	House of Assembly	Lapsed	Bob Such
8. Dignity in Dying Bill 2003 (SA)	House of Assembly	Lapsed	Bob Such
9. Dignity in Dying Bill 2003 (SA)[38]	Legislative Council	Negative: failed Second Reading 13/8[39]	Sandra Kanck
10. Dignity in Dying Bill 2005 (SA)	House of Assembly	Lapsed	Bob Such
11. Voluntary Euthanasia Bill 2006 (SA)	House of Assembly	Lapsed	Bob Such
12. Voluntary Euthanasia Bill 2007 (SA)	House of Assembly	Lapsed	Bob Such
13. Voluntary Euthanasia Bill 2008 (SA)	House of Assembly	Lapsed	Bob Such
14. Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA)	Legislative Council	Negative: failed Third Reading 11/9[40]	Mark Parnell
15. Voluntary Euthanasia Bill 2010 (SA)	House of Assembly	Lapsed	Bob Such
16. Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA)	House of Assembly	Lapsed	Steph Key
17. Consent to Medical Treatment and Palliative Care (End of Life	Legislative Council	Negative: failed Second Reading[41]	Mark Parnell

[35] South Australia, *Hansard,* House of Assembly, 27 July 1995, 2991.
[36] South Australia, *Hansard,* Legislative Council, 9 July 1997, 1782-83.
[37] Referred to Social Development Committee on 25 March 1998.
[38] This Bill was restored as a lapsed Bill: see South Australia, *Hansard*, Legislative Council, 12 November 2003, 552 (Sandra Kanck).
[39] South Australia, *Hansard,* Legislative Council, 4 June 2004, 1748.
[40] South Australia, *Hansard,* Legislative Council, 18 November 2009, 4035.
[41] South Australia, *Hansard,* Legislative Council, 24 November 2010, 1738. There is no tally of the votes on this Bill in the Hansard.

Arrangements) Amendment Bill 2010 (SA)			
18. Criminal Law Consolidation (Medical Defences - End of Life Arrangements) Amendment Bill 2011	House of Assembly	Lapsed	Steph Key
19. Voluntary Euthanasia Bill 2012 (SA)	House of Assembly	Negative: failed Second Reading 20/22[42]	Bob Such
20. Ending Life with Dignity Bill 2013 (SA)	House of Assembly	Lapsed	Bob Such
21. Ending Life with Dignity Bill (no 2) 2013 (SA)	House of Assembly	Lapsed	Bob Such
22. Voluntary Euthanasia Bill 2016 (SA)	House of Assembly	Withdrawn	Steph Key
23. Death with Dignity Bill 2016 (SA)	House of Assembly	Negative: failed Third Reading 24/23.[43]	Duncan McFetridge

[42] South Australia, *Hansard,* House of Assembly, 14 June 2012, 2152.
[43] South Australia, *Hansard,* House of Assembly, 16 November 2016, 8011.

Introduction

[4.10] It is difficult to detail all the arguments put forward in the ongoing VAD debate in South Australia. If VAD was not outright objected to in principle, then it was objected to on the basis that the particular model for consideration before parliament was itself problematic. In South Australia, the approach regarding the proposed regulatory framework of substantive and procedural safeguards of the many VAD bills has differed over time, including the requirement to safeguard against undue influence (or not). Table 4 provides an overview of eligibility requirements, key safeguards and administrative oversight of all VAD bills tabled in South Australia from 1995–2016. The following discussion will consider selected distinguishing features of several VAD bills.

It is important to note at the outset of this discussion that it is evident that parliament never intended VAD to be easily accessible. Multiple conditions were established to access VAD. This was generally exemplified by requiring the person to pass several tests to determine eligibility and by mandating two medical practitioners to be involved in the consent process. An overview of procedure under the Death with Dignity Bill 2016 (SA) illustrates this point.

[4.20] Under the Death with Dignity Bill 2016 (SA) ('DWD Bill') there were multiple criteria to be met prior to being deemed eligible to request VAD.[1] In order to be deemed eligible, the person had to demonstrate that:

- they were a competent adult, aged 18 years or over; and

[1] Many amendments were passed by the House of Assembly when the Death with Dignity Bill 2016 (SA) ('DWD Bill') reached the Committee stage and some of the criteria discussed were amended.

- they had lived in South Australia for at least 12 months; and
- they had been diagnosed with a terminal medical condition that caused suffering intolerable to them; and
- there was no 'reasonably available medical treatment or palliative care options that would … relieve the … suffering in a manner that is acceptable [to them]'; and
- their death has … become inevitable by reason of the terminal medical condition; and
- they do not have impaired decision-making capacity to request VAD.[2]

To avoid potential ambiguity regarding the substantive elements of the eligibility criteria, the DWD Bill explicitly defined 'terminal medical condition', 'incurable', 'suffering' and 'intolerable,' which contained both objective and subjective elements.[3] For instance, in determining whether suffering was intolerable, it was explicitly stated that this was a subjective test 'and need not meet an objective standard'.[4] Additionally, it was explicitly provided that determinations of 'tolerable' and 'intolerable' could not be challenged in any proceedings that sought to delay the administrations of VAD,[5] thus clarifying that the patient is the arbiter on notions of suffering. Moreover, to safeguard against misdiagnosis and error, two independent medical practitioners were required to examine the patient to determine their eligibility for VAD.[6] It is obvious that there were significant steps to complete to ascertain whether the person was even eligible to make a request for VAD. The position regarding two-doctor consent has been varied, with earlier VAD bills adopting a liberal approach to this criterion.[7] However, overtime, a gradual tightening of this requirement has occurred.

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[2] DWD Bill 2016 (SA) ss 9(2)(b)—(e).
[3] Ibid ss 9(4)(a)–(e).
[4] Ibid ss 9(4)(d)(i)–(ii).
[5] Ibid s 9(4)(d)(ii).
[6] Ibid ss 10(1)(b), (c), 11(1)(b), 12(1)(c)(i).
[7] See Voluntary Euthanasia Bill 1995 (SA); South Australia, *Hansard*, House of Assembly, 9 March 1995, 1864–65 (John Quirke); South Australia, Hansard, House of Assembly, 8 June 1995, 2626 (Lorraine Rosenberg). Section 16(2)(d) of the Ending Life with Dignity Bill (no 2) 2013 (SA) mandated that only registered palliative care specialists could provide advice on palliative care options.

Two-doctor consent was an essential feature of the DWD Bill, with both medical practitioners required to provide written information to the patient advising of the:

- diagnosis and prognosis of the person's terminal medical condition
- forms of treatment reasonably available and any associated risks
- palliative care options reasonably available
- medical procedure that may be used to administer VAD and risks associated with it
- non-obligatory nature of VAD, meaning that even if the request is granted, the person is under no obligation to follow through with it.[8]

One contention, however, was that it did not stipulate whether the medical practitioners involved in administering VAD required specialist qualifications. This concern was noted in parliament and amended at the Committee stage[9] by stipulating that either 'medical practitioner[s] must be a specialist, or otherwise have expertise, in terminal medical conditions of the kind from which the person is suffering'.[10] In addition to this, the proposed response regarding mandatory psychiatric referral was also a matter of concern.[11]

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[8] DWD Bill 2016 (SA) ss 11(1)(c)(i)–(vi), 12(1)(d)(i)-(iv). Under the DWD Bill, the second medical practitioner was not required to advise on the medical procedures used to administer VAD or the risks associated with it. This was limited to the first medical practitioner.

[9] South Australia, Hansard, House of Assembly, 16 November 2016, 7993 (Christopher Picton).

[10] Ibid 7993. A potential consequence of this amendment was that it would limit the pool of medical practitioners able to provide VAD. When viewed in context with the narrow eligibility criteria under the DWD Bill, especially the requirement that death occur within six months and mandatory psychiatric assessment, this was apt to create a significant barrier to access. Further discussion of this point is, however, beyond the narrow focus of this thesis; nonetheless, it remains an issue for consideration should this discussion come before parliament in the future.

[11] The involvement of a psychiatrist in a request for VAD did not appear as a safeguard in VAD bills until 2008, when the Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA) ('VE Amendment Bill 2008') provided that referral to a psychiatrist was mandatory if the person was not of sound mind or 'the decision-making ability of the person is adversely affected by the person's state of mind': see VE Amendment Bill 2008 (SA) s 19(3)(c). This requirement was not characteristic of all bills introduced after 2008. In fact, only six bills in total included this provision. It is

Psychiatric referral was a discretionary requirement under the DWD Bill. This provision was engaged if either medical practitioner reasonably suspected that the person was not of sound mind, or their decision-making capacity was adversely affected by their state of mind, or they were acting under any form of duress, inducement or undue influence.[12] The discretionary involvement of a psychiatrist proved to be unpopular, and this was resolved by the Committee amending this provision, rendering psychiatric referral mandatory.[13] As a consequence, these amendments added another layer of scrutiny in the process, as the patient would have been required to consult three specialist medical practitioners — two experts in the person's specific illness and a psychiatrist.

Once all the examinations had been performed and the person was deemed eligible, the next step was to ensure that the request for VAD was properly executed, which had to be done in the presence of two competent adult witnesses.[14] The witnesses did not have to be personally known to the person making the request. However, a degree of independence was necessary, rendering certain persons ineligible to perform this task.[15] Each witness was required to certify, amongst other things, that the person was not acting under any form of duress, inducement or undue influence.[16] Finally, 14 days had to lapse between the examination by the first medical practitioner and the administration of VAD.[17]

important to note that the majority of the bills preferred that psychiatric referral be a discretionary requirement, enlivened when suspicions concerning competency or unacceptable external pressure – including undue influence – were raised.

[12] DWD Bill *2016* (SA) ss 11(2)(a)–(c), 12(2)(a)–(c).

[13] South Australia, *Hansard*, House of Assembly, 16 November 2016, 7976.

[14] See Table 4 for an overview of all these requirements.

[15] DWD Bill s 14(2).

[16] Ibid s 14(1)(c)(v).

[17] Ibid ss 17(1)(d), 18(1)(d).

In summary, the process required under the DWD Bill was complex — more analogous to a decathlon than a 100m sprint. There were multiple hoops to jump through to be deemed eligible to access VAD. If any of the requirements were not satisfied, then the request could not be granted. However, the process described in the DWD Bill was not characteristic of all bills before parliament, although some broad consistency concerning safeguards and procedure is evident.[18]

A few points of consensus …

[4.30] All South Australian VAD bills (except the Voluntary Euthanasia (Referendum) Bill 1996 (SA) as it is not applicable) sought to legalise both forms of VAD. As noted in Chapter 1, two distinct yet associated practices generally come under the term 'VAD'. The fundamental difference between the practices being whether the doctor or the patient themselves administers the lethal substance. Unlike the position adopted in selected jurisdictions in the United States of America, where physician-assisted suicide is permitted but practitioner-administered assisted dying is unlawful,[19] the approach in South Australia was not restricted. All of the bills established a framework permitting both practices. However, the Death with Dignity Bill 2016 (SA) deviated from the existing approach to administration, preferencing self-administration of VAD over physician-administered VAD.[20]

[18] See Table 3 and Table 4 for comparison.
[19] See Chapter 9 for discussion on the law in the US jurisdictions.
[20] DWD Bill s 18(1)(a)(iv); *Voluntary Assisted Dying Act (2017)* (Vic) ('*VAD Act* (Vic)') adopted a similar approach. The patient self-ingesting the medication was preferred over a practitioner-administered option. However, practitioner-administered dying is permitted if 'the person is physically incapable of the self-administration or digestion of the voluntary assisted dying substance' see ss 46(c)(i), 48(3)(a), 53(1)(b). This has also been adopted in the *Voluntary Assisted Dying Act* 2021 (SA) ss 64(c)(i) ('*VAD Act* (SA)').

Another fundamental shared characteristic of the South Australian bills is that VAD was only available to adults. The bills clearly and consistently indicated that only persons 18 years or above could request VAD. This is a departure from the existing legal age of consent in South Australia which is 16 of age, thus reinstating the traditional age of consent to medical treatment.[21] On this point, this approach is consistent with most other jurisdictions where VAD is presently permitted, barring the Netherlands and Belgium where minors (of varying ages depending on the jurisdiction) are permitted to request VAD.[22]

Therefore, whilst some consensus was evident in the proposed legislative response regarding the provision of VAD in South Australia, it then flows that there remained fundamental differences. Although there was broad consistency in recognition of a need to control access to VAD, the means by which this control was achieved was an important distinguishing feature. Further points of contrast were evident in the eligibility criteria; who should be eligible to access VAD beyond persons 18 years and over was a contentious issue. Two dominant approaches — the broad and restrictive approaches — were adopted regarding the definition of the qualifying illness.

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[21] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6 ('*Consent Act*').

[22] See, eg, *Termination of Life on Request and Voluntary Euthanasia (Review Procedures) Act* 2002 (Netherlands) where minors as young as 12 years of age are permitted to make a request for voluntary euthanasia and assisted suicide. However, for minors aged 12–16 years, voluntary euthanasia and assisted suicide can only be carried out if parental consent has been obtained. For minors over 16 years of age, parents need only be involved in the discussions and parental consent is not obligatory. However, an important characteristic for all minors is that they must be deemed to have a reasonable understanding of their interests: see *Termination of Life on Request and Voluntary Euthanasia (Review Procedures) Act* 2002 (Netherlands) arts 2 (2)-(4). These provisions operate in addition to the requirement to the due care provisions set out under the Act. Voluntary euthanasia for severely ill newborns is permitted in the Netherlands; however, this is regulated by the Groningen Protocol: see, eg, Eduard Verhagen and Pieter Sauer, 'The Groningen Protocol – Euthanasia in Severely Ill Newborns' (2005) 352(10) *New England Journal of Medicine* 959; see also Jacob Koopman and Theo Boer, 'Turning Points in the Conception and Regulation of Physician-Assisted Dying in the Netherlands' (2016) 129(8) *American Journal of Medicine* 773. Recent amendments to the Belgian *Act on Euthanasia 2002* removed all age restrictions on VAD: see, eg, Andrew Siegel, Dominic Sisti and Arthur Caplan, 'Pediatric Euthanasia in Belgium'(2014) 311(19) *Journal American Medical Association* 1963; see also Kenneth Chambaere, Marc Roelands and Luc Deliens, 'Euthanasia for Minors in Belgium' (2014) 312(12) *Journal American Medical Association* 1258.

Many points of disagreement

[4.40] The two approaches concerning eligibility criteria are best described as the broad approach and the restrictive approach. Whether the qualifying illness should be defined broadly or access should be restricted was a divisive issue before parliament.

The broad approach

[4.50] Defining who should be eligible to access VAD has been a rigorously debated topic before parliament and many of the discussions centred on this point. For example, the Dignity in Dying Bills (see Table 4) preferred the term 'hopelessly ill', which was defined as

> an injury or illness — (a) that will result, or has resulted, in serious mental impairment or permanent deprivation of consciousness; or (b) that seriously and irreversibly impairs the person's quality of life so that life has become intolerable to that person and there is no realistic chance of clinical improvement.[23]

The breadth and potential ambiguity of this definition was subject to considerable criticism. First, it could be interpreted to include a wide cohort of persons, with a wide variety of illnesses, including trivial ailments, which is generally contrary to the contexts in which VAD is thought to be acceptable.[24] Second, exactly how were the requirements for a 'hopeless illness' to be assessed? Was this to be subjectively determined or was it an objective assessment? The obvious risk with this term was that it failed to provide meaningful guidance on how to construe such an essential provision.[25]

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[23] Dignity in Dying Bill 2005 (SA) ss 4 (a), (b). Almost all of the Dignity in Dying Bills used the same definition for the qualifying illness. However, there was a slight difference in the wording of the Dying in Dignity Bill 2001: see Table 4 which rendered it more liberal that the subsequent Dignity in Dying Bills.
[24] See South Australia, *Hansard*, Legislative Council, 25 July 2001, 2074-75.
[25] See especially South Australia, *Hansard*, Legislative Council, 3 June 2002, 292 (Ian Gilfillan). When the Dignity in Dying Bill 2004 (SA) was before the Committee in the Legislative Council, David Ridgway

The subsequent Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA) ('VE Amendment Bill') appeared to remedy the shortcomings with the Dignity in Dying Bill 2005 (SA). The VE Amendment Bill explicitly restricted access to VAD to persons in 'terminal phase of a terminal illness',[26] thus avoiding the normative questions surrounding construction of the term 'hopeless.' It, however, reverted back to the broad position by also permitting persons with an illness, injury or other medical condition that 'irreversibly impair[ed] the person's life so that life [had] become intolerable to them'[27] to request VAD. It too faced similar criticism before parliament. For instance, taking issue with the broad definition given to the qualifying illness, Bernard Finnigan opined that

> I believe that the model that exists under this legislation is fundamentally flawed in a number of respects … you do not have to have a terminal illness to obtain active voluntary euthanasia or a prescription for a lethal dose [of medication] … That is not a definition that provides a tight restriction on who can access active voluntary euthanasia. That definition could apply to someone suffering from chronic depression or rheumatoid arthritis, or the early stages of multiple sclerosis or Alzheimer's.[28]

Therefore, objection to VAD was not limited to religious, moral and ethical arguments. Significant disagreement over the drafting of the qualifying illness was also a contentious issue, and as some members of parliament argued, broadly defined clauses could logically mean that VAD is not an option reserved for persons at the end of life.[29] However, this was

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moved to clarify and restrict the operation of 'hopeless illness' to explicitly exclude clinical depression alone as a ground to access VAD: see South Australia, *Hansard*, Legislative Council, 5 May 2004, 1483 (DW Ridgeway). The clause as amended was passed by the Committee see South Australia, *Hansard*, Legislative Council, 5 May 2004, 1484.

[26] See Table 4.

[27] VE Amendment Bill 2008 (SA) s 19(1)(b)(ii).

[28] South Australia, *Hansard,* Legislative Council, 28 October 2009, 3761 (Bernard Finnigan); see also South Australia, *Hansard*, Legislative Council, 28 October 2009, 3778 (Caroline Schaefer); South Australia, *Hansard*, Legislative Council, 28 October 2009, 3768 (Carmel Zollo).

[29] Many of the perceived inadequacies of Mark Parnell's VE Amendment Bill 2008 were remedied in his subsequent Bill: the Consent to Medical Treatment and Palliative Care (End-of-Life Arrangements) Amendment Bill 2010 (SA) ('ELC Arrangements Bill'). For example, clauses were inserted that excluded

not the only approach taken. As previously mentioned, the restrictive approach sought to limit who would be eligible to make a request.

The restrictive approach

[4.60] The restrictive approach seeking to limit access to VAD was later favoured by the late Bob Such, who, as a consistent supporter of VAD, was responsible for the introduction of 11 VAD bills into South Australian parliament. Although Dr Such's early bills, such as the Dignity in Dying Bills favoured the broad approach, his subsequent VAD bills represented a significant shift towards a more restrictive approach concerning access to VAD.[30] Of the 11 bills introduced by Dr Such, 9 lapsed due to prorogation; 1 was discharged in the House of Assembly and the Voluntary Euthanasia Bill 2012 (SA) was defeated by a margin of two votes at the second reading stage.[31], There is limited discussion in the *Hansard*, a likely consequence of the majority of Dr Such's bills lapsing. Therefore, whether this position was better received in parliament remains unclear.[32] This silence is perhaps indicative of the House of Assembly's frustration with the nearly annual appearance of VAD in South Australian parliament. However, when the subsequent Voluntary Euthanasia Bill 2016 (SA) ('VE Bill') was tabled in parliament, the failure to restrict access to persons with a terminal illness was critical to its demise,[33]

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mental illness alone as a qualifying condition, independent specialist referral for advice under the Bill was mandated, and dental practitioners were excluded from the definition of medical practitioner to preclude them from assisting a person with an VAD request: see ELC Arrangements Bill ss 6, 10(3)(a), 35(c)(ii). For further discussion in the Committee on the issues with the VE Amendment Bill, see South Australia, *Hansard*, Legislative Council, 19 November 2009, 4015–17, 4026–28.

[30] See Table 4 for a comparative overview of the eligibility criteria.

[31] See South Australia, *Hansard,* House of Assembly, 14 June 2012, 2152.

[32] Of the 11 bills, second reading speeches were given on four bills, with a cumulative total of 10 speeches from members of the House of Assembly see South Australia, *Hansard,* House of Assembly, 22 November 2007, 1835; South Australia, *Hansard,* House of Assembly, 14 February 2008, 2087–88; South Australia, *Hansard,* House of Assembly, 13 November 2008, 934–36; South Australia, *Hansard,* House of Assembly, 24 February 2011, 2650; South Australia, *Hansard*, House of Assembly, 21 March 2013, 4912–17.

[33] Eligible person was defined in the Voluntary Euthanasia Bill 2016 (SA) ss 4, 10 ('VE Bill'); see also South Australia, *Hansard*, House of Assembly, 14 April 2016, 5215 (Vincent Tarzia); South Australia, *Hansard*,

seeing it replaced by the Death with Dignity Bill 2016 (SA) where the requirement for terminal illness was reinstated.[34]

Evidently, discussions on defining the qualifying illness were integral to the dialogue; however, they were only one aspect of the overall debate and the legalisation of VAD in South Australia did not turn on this point alone.[35] The debate in parliament also focussed on the question of substantive safeguards; that is, how should the proposed legislative response balance the competing interests of respecting autonomy whilst protecting individuals from potential abuse?[36] How should a voluntary decision be safeguarded? Protection from, or screening for, undue influence in a request for VAD was one of the substantive safeguards introduced to protect a voluntary decision that formed part of the broader framework of protections that aimed to achieve this objective. It is the reliance on undue influence as a proposed substantive safeguard that sits at the heart of this thesis.

House of Assembly, 14 April 2016, 5216 (Rachel Sanderson); South Australia, *Hansard*, House of Assembly, 20 October 2016, 7346 (Stephen Mullighan); South Australia, *Hansard,* House of Assembly, 20 October 2016, 7347 (David Spiers); South Australia, *Hansard*, House of Assembly, 20 October 2016, 7348-49 (Vicki Chapman).

[34] The VE Bill was replaced by the Death with Dignity Bill 2016 (SA) which was introduced on 20 October 2016. In his Second Reading speech, Duncan McFetridge explained that the motivation behind introducing another VAD Bill, while the VE Bill was still before the House of Assembly was strategic, as 'it became clear that [Steph Key's] bill was facing some opposition, some concerns, and so with her consent … we have put together this new piece of legislation which embodies, encompasses and includes all those amendments that were suggested by members of parliament': see South Australia, *Hansard*, House of Assembly, 20 October 2016, 7339 (Duncan McFetridge). The VE Bill was withdrawn on 2 March 2017; see s 9 of the DWD Bill 2016 (SA) for the eligibility requirements, which departed from the VE Bill concerning eligibility. It did, however, retain the position under the VE Bill regarding the subjective nature of suffering. This position, and other provisions relating to eligibility, were extensively debated and significantly amended at the Committee stage, resulting in a more restrictive model: see DWD Bill 2016 (SA) ss 9(4)(c), (4)(d)(i); South Australia, *Hansard*, House of Assembly, 16 November 2016, 7963 (Christopher Picton); South Australia, *Hansard*, House of Assembly, 16 November 2016, 7970; South Australia, *Hansard*, House of Assembly, 16 November 2016, 7969 (Christopher Picton); South Australia, *Hansard*, House of Assembly, 16 November 2016, 7966; South Australia, *Hansard*, House of Assembly, 16 November 2016, 7970 (Mick Atkinson), 7972 (Christopher Picton); South Australia, *Hansard*, House of Assembly, 16 November 2016, 7972 (Duncan McFetridge); South Australia, *Hansard*, House of Assembly, 16 November 2016, 7973 (Mick Atkinson); South Australia, *Hansard*, House of Assembly, 16 November 2016, 7975.

[35] Further analysis on the substantive elements included in the many VAD bills will not be provided. Table 4, however, outlines some additional criteria.

[36] See, eg, South Australia, *Hansard,* House of Assembly, 2 March 2005, 1824 (Joe Scalzi); South Australia, *Hansard*, Legislative Council, 12 November 2008, 630 (Mark Parnell).

Table 4 – Overview of South Australian Voluntary Euthanasia Bills 1995–2016

Title of Bill	Eligibility	Safeguards	Administrative Oversight
1. Voluntary Euthanasia Bill 1995 (SA)	1. Adult of sound mind with decisional capacity, diagnosed with a terminal illness likely to cause death within 12 months. [1]	1. 2-doctor consent and second doctor must not be involved in the day-to-day care of the patient; 2. consent must be fully informed; 3. 2 witness – 1 medical practitioner and 1 other adult witness – must certify that the person did not appear to be acting under duress.	Not specified.
2. Voluntary Euthanasia Bill 1996 (SA)	1. Adult of sound mind, who is hopelessly ill, defined as; 2. an illness that causes permanent deprivation of consciousness; or 3. irreversibly impairs the person's quality of life so that life has become intolerable to that person.	1. 2-doctor consent and second doctor must not be involved in the day to day care of the patient; 2. consent must be fully informed; 3. VAD request must be witnessed by medical practitioner and 2 other adult witnesses; 4. 2 witnesses must certify that the person did not appear to be acting under duress; 5. 48-hour time lapse between making a request and administering euthanasia.	Not specified.
3. Voluntary Euthanasia (Referendum) Bill 1996 (SA)	1. Bill sought to legalise voluntary euthanasia by referendum. The question proposed to be put to the electors was: *'Do you support the enactment of legislation to regulate and control the practice of voluntary euthanasia subject to stringent safeguards?'*[2]	NA	NA
4. Dignity in Dying Bill 2001 (SA)	1. Adult of sound mind who is hopelessly ill, defined as an illness that will result, or has resulted, in serious mental impairment or permanent deprivation of consciousness; or that seriously and	1. 2-doctor consent and doctors must be independent; 2. consent must be fully informed; 3. Request must be witnessed by medical practitioner and 2 other adult witnesses; 4. Both witnesses and medical practitioner must certify that the person did not appear to be acting under duress;	1. Dignity in Dying Act Monitoring Committee established to: 2. monitor and keep under review the operation and administration of VAD; and

[1] Adult is defined as a person of or over the age of 18 throughout this table.
[2] Voluntary Euthanasia (Referendum) Bill 1996 (SA) ss 2(1), (2).

Title of Bill	Eligibility	Safeguards	Administrative Oversight
	irreversibly impairs the person's quality of life so life is intolerable to that person.	5. 48-hour time lapse between receiving second medical opinion and administering VAD.	3. make recommendations to the Minister on amendments or improvements to the Act; and 4. publish an annual report on VAD.
5. Dignity in Dying Bill 2001 (SA)[3]	As above	As above	As above
6. Dignity in Dying Bill 2002 (SA)	1. Adult of sound mind who is hopelessly ill, defined as an injury or illness that: 2. Will result, or has resulted, in serious mental impairment or permanent deprivation of consciousness; or that seriously and irreversibly impairs the person's quality of life so that life has become intolerable to that person *and there is no realistic chance of clinical improvement.'*[4]	As above	As above
7. Dignity in Dying Bill 2003 (SA)[5]	As Above	As above	As above
8. Dignity in Dying Bill 2003 (SA)[6]	As Above	As above	As above
9. Dignity in Dying Bill 2002 (SA)[7]	As Above	As above	As above
10. Dignity in Dying Bill 2005 (SA)	As Above	As above	As above

[3] Identical bills were introduced into the House of Assembly and the Legislative Council: see South Australia, *Hansard*, House of Assembly, 15 March 2001, 1094-97; South Australia, *Hansard*, Legislative Council, 14 March 2001, 1034-40.
[4] Dignity in Dying Bill 2002 (SA) ss 4(a), (b) (own emphasis added).
[5] Introduced on 26 March 2003: see South Australia, *Hansard*, House of Assembly, 26 March 2003, 2525.
[6] Introduced on 24 September 2003: see South Australia, *Hansard,* House of Assembly, 24 September 2003, 267-68.
[7] Restored on the notice paper as a lapsed bill on 12 November 2003: see South Australia, *Hansard*, Legislative Council, 12 November 2003, 552.

Title of Bill	Eligibility	Safeguards	Administrative Oversight
11. Voluntary Euthanasia Bill 2006 (SA)	1. Adult of sound mind in the terminal phase of a terminal illness and suffering unbearable pain, which cannot be alleviated by pain relief to a degree found acceptable by the patient.	1. 2-doctor consent, doctors must be independent; 2. consent must be fully informed; 3. Palliative care specialist must be consulted if reasonable practicable; 4. Request must be witnessed by 2 doctors and 2 independent adult witnesses; 5. all witnesses must certify that the person did not appear to be acting under duress; 6. Third independent doctor must assess patient and provide confirming medical opinion prior to administration of VAD; 7. 48 hours must elapse between confirming medical opinion and administration of VAD.	1. Registrar assigned to keep record of VAD requests and any revocations; 2. Vested with broad power to inquire into requests to confirm accuracy of information; 3. Doctor must get a registered copy of VAD request from Registrar prior to administration; 4. Voluntary Euthanasia Monitoring Committee established to: 5. monitor and keep under review the operation and administration of VAD; and 6. make recommendations to the Minister on amendments or improvements to the Act; 7. publish an annual report on VAD.
12. Voluntary Euthanasia Bill 2007 (SA)	As above	As above	As above
13. Voluntary Euthanasia Bill 2008 (SA)	As above	As above	As above
14. Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA)	1. Adult of sound mind who: 2. is in the 'terminal phase of a terminal illness; or 3. has an illness, injury or other medical condition that results in permanent deprivation of consciousness or irreversibly impair the person's quality of life to that life has become intolerable to that person.	1. Person requesting VAD must be given information by a doctor regarding the diagnosis and prognosis of their illness/condition, forms of treatment reasonably available and risks associated with a particular treatment, palliative care options, and the voluntary euthanasia procedure and inherent risks; 2. Psychiatric referral required if doctor suspects that the person is of unsound mind or decision making ability is adversely affected by their state of mind;	1. Voluntary Euthanasia Board of South Australia established under the Act; 2. vested with the function to advise the Minister on matters deemed appropriate by the Board and to carry out any functions as required by the Act; 3. Registrar appointed by the Board to keep a register of VAD

Title of Bill	Eligibility	Safeguards	Administrative Oversight
		3. 24 hours must lapse between preliminary medical appointment and making of formal VAD request for active requests. Period increased to 7 days for advance requests; 4. The doctor and one adult witness must certify that the person did not appear to be acting under duress.	requests and contain all requisite documents in the register; 4. Board vested with power to make certain declarations and orders, conduct inquiries on their own initiative regarding a request for VAD and summons persons to answer questions or produce documents; 5. The Board must publish an annual report on VAD
15. Voluntary Euthanasia Bill 2010 (SA)	1. Same definition as the Voluntary Euthanasia Bill 2006 (SA) above.	Same as the Voluntary Euthanasia Bill 2006 (SA) above.	1. Same as the *Voluntary Euthanasia Bill 2006* (SA) above.
16. Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA)	1. Adult of sound mind who: 2. is in the terminal phase of a terminal illness; or 3. suffering from an illness, injury or other medical condition (excluding mental illness) that results in permanent deprivation of consciousness; or irreversibly impairs the person's quality of life so life has become intolerable to that person.	1. Person requesting VAD must be given information by a doctor regarding the diagnosis and prognosis of their illness/condition, forms of treatment available and associated risks, palliative care options, and the voluntary euthanasia procedure and inherent risks; 2. 2-doctor consent, and second doctor must be a specialist in the person's illness/injury/condition; 3. Request must be made in the presence of a prescribed witness;[8] 4. Psychiatric referral discretionary; 5. 24 hours must elapse between preliminary medical appointment and making of formal VAD request for active requests. Period increased to 7 days for advance requests.	1. Voluntary Euthanasia Board of South Australia established under the Act; 2. Board vested with the function to advise the Minister on matters deemed appropriate by the Board and to carry out any functions as directed by the Minister or required by the Act; 3. Registrar appointed by the Board to keep a register of valid VAD requests and contain all requisite documents in the register; 4. Board vested with power to make certain declarations and orders, conduct inquiries on their own initiative regarding a request for VAD and summons

[8] Undue influence provisions included in this bill: see Table 5 below.

Title of Bill	Eligibility	Safeguards	Administrative Oversight
			persons to answer questions or produce documents; 5. Board does not have general power to authorise or approve requests, however it may make orders declaring a request void upon investigation by application or on its own initiative; 6. Board must publish an annual report on VAD
17. Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA)[9]	As Above	As above	As above
18. Criminal Law Consolidation (Medical Defences — End of Life Arrangements) Amendment Bill 2011 (SA)	1. Adult of sound mind with an illness, injury or other medical condition that irreversibly impairs the person's quality of life so life had become intolerable to them.	1. Doctor administering VAD must be the treating doctor of the person; 2. The person must have expressly requested VAD;	NA
19. Voluntary Euthanasia Bill 2012 (SA)	1. Same definition as the Voluntary Euthanasia Bill 2006 (SA) above.	1. 2 doctor consent and doctors must be independent; 2. Consent must be fully informed; 3. 1 doctor must be the person's treating doctor; 4. Palliative care specialist must be consulted if reasonably practicable; 5. Request must be witnessed by 2 doctors and 2 independent adult witnesses; 6. All witnesses must certify that the person did not appear to be acting under duress;	1. Registrar assigned to keep record of VAD requests and any revocations; 2. Vested with broad power to inquire into requests to confirm accuracy of information; 3. Doctor must get a registered copy of VAD request from

[9] Identical to the Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA). The same Bill was introduced both houses of Parliament in the same session.

Title of Bill	Eligibility	Safeguards	Administrative Oversight
		7. Third independent doctor must assess patient and provide confirming medical opinion prior to administration of VAD;; 8. 48 hours must lapse between the confirming medical opinion and administration of VAD.	Registrar prior to administering VAD; 4. Voluntary Euthanasia Monitoring Committee established to monitor and keep under review the operation and administration of VAD and make recommendations to the Minister on amendments or improvements to the Act; 5. The Committee must publish an annual report on VAD.
20. Ending Life with Dignity Bill 2013 (SA)	1. Adult of sound mind with a terminal illness that is causing unbearable suffering, which cannot be alleviated to suitable degree**.**	1. 2 independent doctors must personally examine the person and fully inform the person of the diagnosis and prognosis of their illness, available treatments and the likely side effects and outcomes, palliative care options, proposed VAD procedure and feasible alternatives; 2. 1 doctor must be the person's treating doctor; 3. Palliative care specialist must be consulted if reasonably practicable; 4. VAD request must be witnessed by 4 witnesses: 2 medical practitioners who assessed the person and 2 other adult witnesses; 5. Psychiatric referral discretionary; 6. Third independent doctor must personally examine patient and provide a confirming medical certificate; 7. VAD can only be administered if it the request is registered in the register; 8. 48 hours must lapse between the confirming medical opinion and administration of VAD.	1. Registrar appointed to keep a register of all active VAD requests; 2. Registrar vested with broad discretionary power to conduct an inquiry into an VAD request; 3. Voluntary Euthanasia Board established to oversee operation of the Act; 4. Board has power to conduct investigation on application or by their own motion & make orders or declarations regarding a euthanasia request, but not to approve all VAD requests; 5. Board must publish an annual report on VAD
21. Ending Life with Dignity Bill (No 2) 2013 (SA)	**1.** Adult of sound mind diagnosed with a terminal illness, with no real prospect of recovery or remission of symptoms, and suffering unbearable pain which cannot be adequately alleviated.	1. 2 independent doctors must personally examine patient and fully inform the person of the diagnosis and prognosis of their illness, available treatments and the likely side effects and outcomes, palliative care options, proposed VAD procedure and feasible alternatives; 2. 1 doctor must be the person's treating practitioner;	1. Voluntary Euthanasia Board established to oversee operation of the Act; 2. Registrar appointed to keep a register of all active euthanasia requests;

Title of Bill	Eligibility	Safeguards	Administrative Oversight
		3. Palliative care specialist must be consulted to advise how palliative care may mitigate symptoms; 4. Request must be witnessed by 4 adults: 2 must be the doctors giving informed consent, other 2 must be adults of sound mind; 5. Psychiatric referral discretionary; 6. Third independent medical practitioner must personally examine patient and provide a confirming medical certificate; 7. VAD can only be administered if it the request is registered in the register; 8. 48 hours must elapse between the confirming medical opinion and administration of VAD	3. Registrar vested with discretionary power to conduct an inquiry into request; 4. Voluntary Euthanasia Board established under the Act; 5. Board has power to conduct investigation on application or by their own motion & make orders or declarations regarding a VAD request, but not to approve all VAD requests; 6. Board must publish an annual report on VAD.
22. Voluntary Euthanasia Bill 2016 (SA)	1. Competent adult with decision-making capacity who is subject to unbearable and hopeless suffering and has been resident in South Australia for 6 months.	1. Preliminary medical examination must be patient initiated; 2. 2 independent doctors must personally examine the patient and provide them with written information concerning their condition, treatments available and associated risks and the VAD procedure and any risks associated with it;[10] 3. Psychiatric referral discretionary; 4. Request must be witnessed by 1 independent competent adult; 5. Competent adult person must witness request; 6. 48 hours must elapse between requesting VAD and administration.	Not specified

[10] Only the first medical practitioner is required to inform the patient of the VAD procedure and associated risks: see VE Bill (SA) s 12(1)(c)(iii)

Title of Bill	Eligibility	Safeguards	Administrative Oversight
23. Death with Dignity Bill 2016 (SA)	1. Competent adult, with decision making capacity suffering from a terminal medical condition which is causing intolerable suffering to the person and there is no reasonably available medical treatment or palliative care that would relieve the person's suffering. 2. Additionally, death must be inevitable and they must have lived in South Australia for at least 12 months preceding the making of a request.	1. Preliminary medical examination and assessment must be initiated by the patient; 2. 2 independent doctors must individually examine and assess the patient and provide written information concerning their condition, treatment options available and associated risks, palliative care options and medical procedures that may be used to administer VAD[11] and the non-obligatory nature of the request if granted; 3. Psychiatric referral discretionary; 4. 2 competent adult witnesses must witness the completed VAD request form; 5. 14 days must elapse between the initial medical examination and the administration of VAD.	Not specified

[11] The second doctor was not under an obligation to provide the person with information concerning the VAD procedure: see DWD Bill 2016 (SA) ss 11(c)(i)–(vi), 12(d)(i)–(iv).

Introduction

> The key element, and I have said this as often as I can when talking about this, V is for 'voluntary'. It is about voluntary euthanasia. I distinguish it from straight euthanasia, which is where you take your dog to the vet and ask for it to be put down as an act of compassion. The dog is not the one making the choice, you are. Voluntary euthanasia is all about the patient themselves making a choice about their life.[1]

> No-one … can be compelled to be involved in this process unless they choose to do so. I think the very name 'voluntary euthanasia' suggests that it is a conscious, deliberate decision.[2]

> [Witnesses] need to be clear in their own minds that there is no coercion, inducements or other pressures on this person. In fact, if people are found to have been acting in an unethical or coercive manner, there are severe penalties for those people in this bill, up to 10 years' gaol. There are severe penalties. There are safeguards.[3]

[5.10] The above quotes, taken from the second reading speeches of the Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA), the Ending Life with Dignity Bill 2013 (SA) and the Death with Dignity Bill 2016 (SA), demonstrate that voluntariness and free choice were vital principles which these VAD bills sought to defend. Safeguarding against undue influence was one mechanism that aimed to uphold these key principles; however, it was only introduced as a vital protection in 2010, where Mark Parnell and Steph Key — who introduced identical VAD bills into the Legislative Council and House of Assembly respectively, days apart[4] — sought to establish a more stringent framework to protect against abuse.[5] Since then, undue influence has remained as a statutory safeguard in the majority of subsequent VAD bills introduced in

[1] South Australia, *Hansard,* Legislative Council, 29 September 2010, 964 (Mark Parnell).
[2] South Australia, *Hansard*, House of Assembly, 7 February 2013, 4259 (Bob Such).
[3] South Australia, *Hansard,* House of Assembly, 20 October 2016, 7340 (Duncan McFetridge).
[4] Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA) ('ELA Bill').
[5] South Australia, *Hansard,* Legislative Council, 29 September 2010, 962-65 (Mark Parnell).

South Australia. There has been no critical analysis of the appropriateness of undue influence as a substantive statutory safeguard in this context, although it has been a consistent provision. The following discussion will detail the proposed legislative response to safeguarding against undue influence. For ease of reference, an overview of these provisions is provided in Table 5, situated at the close of this chapter.

'V' is for voluntary: The proposed response to safeguarding against undue influence

[5.20] The statutory response to safeguarding against undue influence was not always consistent, and important points of distinction were evident. The first important difference was that undue influence operated in two distinct ways. First, it was included as a substantive safeguard, requiring medical practitioners and witnesses to actively assess whether the person was being unduly influenced to make a request for VAD. Second, undue influence was included as a criminal offence. The criminalisation of undue influence was the most consistent response to undue influence under the bills and the majority, 19 in total, included this provision.[6] While the criminalisation of undue influence reinforces the legislature's intent to strictly safeguard a voluntary decision and acts as a deterrent for such behaviour, consideration of any issues that may arise as a result of the criminalisation of undue influence is beyond the focus of this thesis and will not be discussed.

Undue influence was not included as a substantive safeguard in the early VAD bills tabled in parliament. Therefore, there was no requirement for medical practitioners or witnesses to assess for elements of undue influence. Safeguarding a request for VAD from behaviour that would undermine the voluntariness of a decision was still a feature of the

[6] This has also been retained under the *Voluntary Assisted Dying Act 2021* (SA) ss 100, 101 ('VAD *Act* (SA)').

proposed legislative framework nonetheless. For example, many of the Dignity in Dying bills explicitly stated in the objects clause that the objects are to ensure that, amongst other things, 'people who may want to request euthanasia … are not subject to duress or other undue pressure to make a request'.[7] Under the Death with Dignity Bill 2005 (SA), the corresponding duty placed on medical practitioners and witnesses was that they had to certify that the person making the request for VAD did not appear to be acting under duress.[8] In 2010, however, the framework of protections broadened to include protection against undue influence.

In an attempt to remedy the perceived shortcomings with his previously defeated Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA),[9] Mark Parnell introduced the Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA) ('ELA Bill'). Comparisons between the 2010 bills and the 2008 bill featured significantly in his Second Reading speech, where it was highlighted that many of the substantive and procedural safeguards and eligibility criteria had been tightened.[10] The new approach taken under the ELA Bill required two doctors — the requesting practitioner and the specialist practitioner — to actively examine for undue influence in a request for VAD. If either suspected that a person was acting under undue influence, then the mandatory psychiatric referral provisions were engaged to confirm or deny the suspicion.[11] In cases where psychiatric referral was mandated, the psychiatrist was then the ultimate arbiter on whether the individual was

[7] Dignity in Dying Bill 2005 (SA) s (3)(c); see also Table 5.
[8] Dignity in Dying Bill 2005 (SA) s 9(2).
[9] South Australia, *Hansard,* Legislative Council, 29 September 2010, 962–65 (Mark Parnell).
[10] South Australia, *Hansard,* Legislative Council, 29 September 2010, 963–64 (Mark Parnell). Steph Key was silent in her Second Reading speech to the House of Assembly concerning undue influence provisions in the ELA Bill: see South Australia, *Hansard,* House of Assembly, 16 September 2010, 1232 (Steph Key).
[11] See Table 4 and Table 5.

being unduly influenced, and if so, this was grounds to deny the request,[12] as it had not been voluntarily made — a fundamental principle that the ELA Bills sought to uphold.

The majority of VAD bills rendered psychiatric referral a discretionary requirement, although as discussed at **[4.20]** above, amendments to the DWD Bill changed this position when it was before the Committee making of referral a mandatory condition. The burden for determining questions of undue influence, therefore, predominantly rested on the requesting practitioner and the specialist practitioner as they were effectively positioned as gatekeepers on the existence of undue influence. If the person requesting VAD passed this first undue influence checkpoint under the ELA Bill, assuming that all other eligibility criteria were satisfied, to finalise the request, the request practitioner and a prescribed witness were required to certify on the VAD request that 'the person was not acting under any form of … undue influence',[13] after having made reasonable enquiries on this point.

The ELA Bills were the first to include undue influence as a substantive safeguard. No definition or guidance on undue influence was provided in the proposed legislative framework — a position that was retained in all VAD bills where this was a requirement. Moreover, the ELA Bills required the request practitioner and the prescribed witness to make *reasonable enquiries* into questions of undue influence prior to certifying that they were of the opinion that the person was not being unduly influenced to make the request. This placed a positive duty to investigate something that they were unlikely to a have sufficient understanding of, with no further clarification provided in the legislation on this point — a significant risk given the historical legal origin of undue influence.[14]

[12] ELA Bill ss 35(3)(d)(iii), (vi).
[13] Ibid s 35(6)(c).
[14] Section 35(6) of the ELA Bill permitted regulations to be passed concerning this provision.

Subsequent VAD bills did not retain the 'reasonable enquiries' element, instead adopting the requirement that the individual did not appear to be acting under undue influence, a slight deviation of the position adopted in the ELA Bill. Protection against undue influence was largely retained as a substantive safeguard, with many of the subsequent VAD bills requiring medical practitioners to assess for undue influence in a request and witnesses to certify that they are of the opinion that the person was not being unduly influenced to make the request.[15] Although the appropriateness of undue influence as a statutory safeguard in proposed VAD legislation was repeatedly overlooked by the legislature, the requirement to call upon witnesses to act as arbiters on technical matters did draw some criticism. For example, speaking in opposition of the Dignity in Dying Bill 2001 (SA) ('DD Bill'), former Attorney-General, Kenneth Griffin, questioned the heavy burden placed on witnesses under the DD Bill. Although undue influence had yet to make its debut as a substantive safeguard, Griffin's criticism of the witness provisions resonates today. On this point, Griffin opined that

> [a] witness is any adult of or above the age of 18, and that is any adult who happens to be available. Two witnesses have to be present at the making of any formal request for euthanasia. It is important to note that each must certify that the patient appeared to be of sound mind, appeared to understand the nature and implications of the request and did not appear to be acting under duress. I would suggest that that is asking a lot of people and, in the circumstances, one questions the reason for the witnesses, because it cannot be that they offer any expertise on any of the questions — for example, where the person appears to be of sound mind — for there is no expert qualification required, even on such a difficult question.[16]

This argument neatly encapsulates one of the key issues raised here with undue influence. How are witnesses going to enhance protection for a voluntary decision if they cannot offer any expertise on questions of undue influence? Griffin aptly highlights the ostensible deficiencies with aspects of the DD Bill, not all of which were remedied in subsequent VAD bills. It is near impossible to engage in further discussion on the legislature's position

[15] See Table 5.
[16] South Australia, *Hansard,* Legislative Council, 25 July 2001, 2076 (Kenneth Griffin, Attorney-General).

regarding undue influence as a substantive safeguard in proposed VAD legislation in South Australia beyond highlighting that it was incorporated into the statutory framework of protections for a voluntary decision in the majority of bills tabled in the 2010s. There is no discussion of undue influence in the *Hansard* which would provide insight into the mechanics of it. It is evident though that the legislature intended to enhance protections for a voluntary decision by incorporating undue influence as an added measure to achieve this objective. This is evinced by the fact that undue influence is distinct from the related doctrine of common law duress, which was also a substantive safeguard under the majority of VAD bills. At law, duress and undue influence are separate doctrines. The protection afforded by undue influence is more far-reaching than duress, as it recognises that subtle influences, not amounting to threats of physical violence, can still vitiate a voluntary decision. But the question remains whether those called upon to undertake this examination are in a position to discern the key differences between duress and undue influence. Undue influence — or duress — was never defined and no explication was provided concerning how an assessment of it was to be performed, therefore, potentially failing to provide any meaningful protection of a voluntary decision. Consequently, important issues have been overlooked concerning the practicalities of undue influence, which potentially nullifies the overall objective of creating a robust framework of provisions aimed to protect a voluntary decision.

Part 3 considers undue influence, and examines how it is a legal term, a creation of equity, and is now applied in the area of probate. The next Part examines how can undue influence enhances protection for a voluntary decision if the people called upon to examine its existence are not equipped with the appropriate tools to undertake this examination? It is akin building a building a house without a solid foundation. Instead of providing the occupants with security and safety, it is likely to place them in harm's way.

Table 5 – Proposed legal response to safeguarding against undue influence in South Australia 2010–2016

Title of Bill	Legal Response to Safeguard Against Undue Influence	Offence of Undue Influence
1. Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA)	1. If either doctor suspects that a person making a request for VAD is acting under any form of undue influence then, prior to approving a request, they must refer the person to a psychiatrist for assessment; 2. The request doctor and one witness must certify that, after making reasonable enquiries, they formed the opinion that the person was not acting under any form of undue influence.	Yes – s 47 Maximum penalty: • Where person dies as a result 20 years imprisonment; or • In any other case, 10 years imprisonment
2. Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA)[1]	As above	As above
3. Ending Life with Dignity Bill 2013 (SA)	1. If either doctor suspects that a person requesting VAD is acting under any form of undue influence then prior to approving a request they must refer the person to a psychiatrist to confirm or deny the suspicion; 2. All witnesses must certify that the person did not appear to be acting under any form of undue influence.	Yes – s 35 Maximum penalty: 10 years imprisonment
4. Ending Life with Dignity Bill (No 2) 2013 (SA)	1. If either doctor suspects on reasonable grounds that a person requesting VAD is acting under any form undue influence, then prior to approving a request, they must refer the person to a psychiatrist to confirm or deny the suspicion; 2. All witnesses must certify that the person who made the request did not appear to be acting under any form of undue influence.	Yes – s 34 Maximum penalty: 10 years imprisonment
5. Voluntary Euthanasia Bill 2016 (SA)	1. If either doctor reasonably suspects that a person making a request for VAD is acting under any form undue influence then prior to approving the request the person must be referred to a psychiatrist to confirm or deny the suspicion;	Yes – s 25 Maximum penalty 10 years imprisonment

[1] The ELA Bills were introduced into both houses of parliament simultaneously.

	2. Each witness must certify that they are of the opinion that the eligible person was not acting under any form of undue influence in relation to their request for VAD.	
6. Death with Dignity Bill 2016 (SA)	1. If either doctor reasonably suspects that a person requesting VAD is acting under any form undue influence, then prior to approving the request, the person must be referred to a psychiatrist to confirm or deny the suspicion; 2. Each witness must certify that they are of the opinion that the eligible person was not acting under any form of undue influence in relation to their request for VAD.	Yes – s 27 Maximum penalty 10 years imprisonment

Chapter 6: Gradual tightening of the response to safeguarding a voluntary decision in South Australia

Introduction

[6.10] It is clear from the discussion in Part 1 that expanding end-of-life options to include VAD has been a topical issue in South Australia for over two decades. All attempts at law reform were unsuccessful until 24 June 2021, when the Voluntary Assisted Dying Bill 2020 (SA) ('VAD Bill (SA)') passed the legislature, ending a 25-year streak of failed law reform in this space. The purpose of Part 1 was to analyse South Australia's response to attempted law reform for VAD. This discussion, although broad in focus, formed an important part of the narrative and was key to understanding VAD from a uniquely South Australia perspective — a task that has not previously been undertaken. How best to control and regulate the provision of VAD varied, with many different bills tabled in parliament since 1995, although some broad consensus was evident regarding important foundational elements, such as the minimum age of consent. There were, however, significant points of distinction, illustrating that VAD was a divisive issue before the Parliament of South Australia. The previous bills and corresponding debates are an important part of the discussion, providing necessary insight into what parliament deemed to be a robust framework of substantive and procedural safeguards.

Whilst the points of distinction were many, there was general agreement that a strong framework of purposeful safeguards was essential to protect against abuse and misuse. Ensuring that a decision to access VAD was voluntarily made was a vital object of most VAD bills in South Australia. The legislative response to meet this objective was to ensure that voluntariness was rigorously safeguarded. Protection against undue influence was one of the mechanisms employed to meet this end.

In Chapter 5, the proposed statutory response to safeguarding against undue influence was examined. Several VAD bills, discussed in Table 5 above, required medical practitioners and lay witnesses to determine questions of undue influence and, in some circumstances, certify that the person requesting VAD was not acting under undue influence. Whilst the intent behind providing broad protection against behaviour that would undermine a voluntary consent is not in issue, the use of undue influence as the term of choice is. As will be considered in Part 3, undue influence is a complicated legal doctrine that has its origins in equity. The question considered here is whether safeguarding against undue influence actually provides meaningful protection for a voluntary decision or exposes patients and medical practitioners to unacceptable risk. Now that the response to safeguarding against undue influence in South Australia has been clearly articulated, this discussion will turn to the response implemented in other jurisdictions that currently permit some form of VAD. The purpose for this shift in focus is that jurisdictions that have permissive VAD laws are a point of reference for jurisdictions where legalisation of VAD has, or continues to be, a live issue, such as South Australia, thus providing important insight into safeguarding against improper external pressures.

Where to now?

[6.20] Over the past several years, the number of jurisdictions to pass VAD legislation has increased significantly. Table 2 in Chapter 1 outlined these jurisdictions, describing what form of VAD was permitted and the term of choice adopted there. At the time of writing, 16 jurisdictions[1] have enacted VAD legislation and will be considered in Part 2. These are:

[1] Tasmania and South Australia have been excluded from this tally as consideration of these statutes, especially the *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), are beyond the focus of this discussion due to the recency of these developments.

1. Victoria, Australia
2. Western Australia, Australia
3. Canada
4. Quebec, Canada
5. Belgium
6. The Netherlands
7. Luxembourg
8. Oregon, USA
9. Washington, USA
10. Vermont, USA
11. California, USA
12. Washington D.C., USA
13. Hawaii, USA
14. New Jersey, USA
15. Maine, USA
16. Colorado, USA.

The response to regulating and controlling access to VAD in these jurisdictions is varied. However, a shared characteristic between these laws is that they all recognise the need to ensure that a request for VAD has been voluntarily made. The purpose of Part 2 is to detail the response to safeguarding a voluntary decision in these jurisdictions. This comparative legal analysis is important and will establish a solid foundation for the final chapter of this thesis when recommending the best path forward for South Australia to allay concerns raised with screening for undue influence as a key protection for a voluntary decision.

> [R]espect for autonomy intersects with the protection of vulnerable persons: on the one hand, '[v]ulnerability, in and of itself, must not preclude the expression and recognition of an autonomous choice to pursue physician-assisted death' on the other, 'vulnerability … may impede or distort the expression of autonomy, when choices are coerced or induced.[2]

[2] *Truchon and Gladu v A-G (Canada) and A-G (Quebec)* [2019] QCCS 3792, [79] (Baudouin J) citing *Final Report on Options for a Legislative Response to Carter v Canada, Consultations on Physician-Assisted Dying – Summary of Results and Key Findings* (15 December 2015) 2.

Introduction

[7.10] At the time of writing, 16 jurisdictions world-wide have enacted some form of VAD, either as an act of parliament,[1] by public referendum — popular in the United States of America[2] and known as a 'Ballot Initiative' — or through the judiciary.[3] Although the VAD movement is gaining momentum, it is unlikely there will ever be universal acceptance of the concept, as many diverse — and divisive — arguments have been posited both for and against its legalisation. Consideration of these arguments is beyond the narrow focus of this thesis. However, it is acknowledged that diversity of opinion is beneficial to the overall development of the law in this area, as the exchange of ideas is often key to facilitating change for the better. A frequent argument that arises in the debate, demonstrated in the quote provided at the outset of this Part, is the tension between individual autonomy and protection of the vulnerable. It is unlikely that these competing concepts will ever reach a state of equilibrium, because weighing these principles is largely idiosyncratic and open to individual interpretation. Thus, it is difficult to reconcile these competing interests due to their subjective nature.

Legislatures have, however, attempted to balance the scales through designing a carefully structured legislative regime. While the focus of this thesis is on the appropriateness of undue influence as a substantive safeguard in proposed VAD legislation in South Australia, it is important that time is taken to understand the approach towards

[1] See, eg, *Voluntary Assisted Dying Act 2017* (Vic) ('*VAD Act* (Vic)'); *Voluntary Assisted Dying Act 2019* (WA) ('*VAD Act* (WA)'); see also Thaddeus Mason Pope, 'Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures' (2018) 48(2) *New Mexico Law Review* 267; Gunter Lewy, *Assisted Death in Europe and America: Four Regimes and their Lessons* (Oxford University Press, 2011).
[2] See especially Pope (n 1).
[3] See *Carter v Canada (Attorney-General)* [2015] 1 S.C.R. 331.

safeguarding a voluntary request for VAD in other jurisdictions. In order to build a solid foundation for the recommendations put forward to mitigate the concerns of undue influence, it is necessary to examine the legislative response to protecting voluntary requests in other jurisdictions.

Safeguarding a voluntary request from external pressure is one of the pivotal protections built into VAD legislation. While differences are evident between the jurisdictions concerning the tests to protect voluntariness, little is known about the substantive differences on this point alone and whether there are nuanced approaches. As was explored in Part 1, one of the legislative responses proposed in South Australia was to place a positive obligation on medical practitioners and lay witnesses to assess for elements of undue influence, which, for reasons articulated in Part 3, is problematic. It will become apparent throughout this discussion that undue influence appears as a core safeguard in several jurisdictions, yet clarity around its efficacy in this context is elusive. Table 6, located at the close of this chapter, outlines the legislative response to safeguarding a voluntary request in all jurisdictions that have enacted VAD legislation and will be referred to throughout this Part. This includes discussion of the *Voluntary Assisted Dying Act 2019* (WA) in Western Australia which recently commenced operation. As shown in Table 6, a wide variety of language and terminology is adopted that serves to protect a voluntary request from some form of external pressure. Therefore, the chapters in Part 2 will analyse legislation in jurisdictions that currently permit VAD,[4] with a view

[4] It is important to acknowledge that Colombia currently permits VAD. Analysis of VAD law in Colombia proved challenging due to the difficulty in accessing primary and secondary sources of law in English. Therefore, to avoid error and an incomplete picture of VAD being portrayed in Colombia, the decision was made to exclude Colombia from this analysis. For general discussion on VAD in Colombia, see Juliana Maria Mendoza-Villa and Luis Andres Herrera-Morales, 'Reflections on Euthanasia in Colombia' (2016) 44(4) *Colombian Journal of Anesthesiology* 324; 'Resolucion 1216 de 2015', *Nueva eps gente cuidando gente* (Web Page, 26 May 2015) <https://www.nuevaeps.com.co/resolucion-1216-2015>; Lynda Lopez Benavides, 'The Right to Die with Dignity in Colombia' (2018) 6(6) *Forensic Research & Criminology International Journal* 426.

to draw out similarities and key points of difference with the proposed response in South Australia. However, important caveats on the discussion need to be addressed. First, a historical discussion detailing the path to reform in each jurisdiction will be limited. It is acknowledged that in many jurisdictions the path to reform was not unencumbered and is best described as piecemeal, marred by failed attempts and/or legal challenges.[5] This historical discussion, whilst important to the overall development of VAD in modern society, is beyond the narrow focus of this thesis. Second, a comprehensive discussion on all legislative safeguards or the processes in place to make a valid request will not be considered. The focus here will be on the legislative response to safeguarding a voluntary request from some form of external pressure. In confining this discussion, it is not implied that the remaining safeguards are without fault or limitation. Critical analysis of them simply cannot be accommodated in this project. However, an overview of the recent rapid development of the legal landscape in this area is justified. It is evident that the wave of law reform has not yet broken and will likely see further development, thus heightening the importance of the recommendations posited at the close of this thesis.

The recent (rapid) development of VAD

[7.20] The legal landscape concerning VAD has changed significantly over the last decade with many more jurisdictions enacting VAD legislation. While the VAD movement has recently gained momentum, when positive reform first started in the 1990s progress was slow and piecemeal. Public interest concerning the parameters of end-of-life law and practice intensified in the mid-1990s, with courts and parliaments in many jurisdictions

[5] See especially Pope (n 1).

being called upon to consider VAD.[6] Here, in Australia, the Northern Territory set a precedent in 1995 by becoming the first jurisdiction in the world to enact VAD legislation. The *Rights of the Terminally Ill Act 1995* (NT) ('*ROTI Act*') came into force on 1 July 1995 but was not accepted uncritically, which ultimately resulted in it being invalidated on 25 March 1997 by the Commonwealth Government enacting the *Euthanasia Laws Act 1997* (Cth), which is still in force[7] A few months prior to the enactment of the *ROTI Act*, Oregon, in the United States of America ('USA'), was also inching toward law reform by enacting the *Death with Dignity Act* ('*DDA* (Oregon)').[8] However, 15 days before the Act was set to come into force, opponents of VAD sought to have the law invalidated and a permanent injunction was granted, delaying the operation of the *DDA* (Oregon) until 27 October 1997 — nearly two years after its initial start date.[9] The *DDA* (Oregon) survived several subsequent judicial challenges and has now been in force for over two decades.

In the 2000s, successful law reform for VAD grew steadily, with the Netherlands and Belgium both enacting VAD legislation in 2002,[1] followed by Washington (USA) in 2008[2]

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[6] See, eg, *Rights of the Terminally Ill Act 1995* (NT); Voluntary Euthanasia Bill 1995 (SA); Voluntary Euthanasia Bill 1996 (SA); *Euthanasia Laws Act* 1997 (Cth); *Washington v Glucksberg*, 521 U.S. 702 (1997); *Vacco v Quill*, U.S. 193 (1997); *Lee v Oregon*, 891 F. Supp. 1429 (D.Or.1995); *Lee v Oregon*, 107 F. 3 1382 (9 Circ. 1997); *Oregon Death with Dignity Act*, O.R.S. (2019), 127.800–127.897; *Rodriguez v British Columbia (Attorney General)*, [1993] 3 S.C.R. 519; Jacob JF Visser and Herman H van der Kloot Meijburg, 'The Long Road to Legalizing Physician-assisted Death in the Netherlands' (2003) 11 *Illness, Crisis and Loss* 114; H Leenen, R van Boxtel, M Kamp et al, 'Bill on Euthanasia and Assisted Dying in the Netherlands' (1998) 5(3) *European Journal of Health Law* 299; see also; Pope (n 1).

[7] Under s 122 of the *Commonwealth of Australia Constitution Act 1900* (Imp) 63 & 64 Vict, c 12, s 9, the Commonwealth is conferred constitutional power to make laws for the Territories; see also *Spratt v Hermes* (1965) 144 CLR 226; George Williams and Matthew Darke, 'Euthanasia Laws and the Australian Constitution' (1997) 20 *University of New South Wales Law Journal* 647. The *Euthanasia Laws Act 1997* (Cth) remains in force, meaning that Australian Territories are prohibited from enacting VAD legislation.

[8] *Oregon Death with Dignity Act*, O.R.S. (2019), 127.800–127.897.

[9] See Pope (n 1) 277; Lewy (n 1).

[1] *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Nth); 'The Belgian Act on Euthanasia of May, 28th 2002' (2003) 10 *European Journal of Health Law* 329. For detailed discussion on the path to law reform in both the Netherlands and Belgium, see especially Gunter Lewy, *Assisted Death in Europe and America: Four Regimes and their Lessons* (Oxford University Press, 2011).

[2] *Washington Death with Dignity Act,* RCW Title 70, c. 70.245–903 ('*DDA* (Washington)'). On 31 December 2009, the Supreme Court of Montana ruled that physicians could lawfully provide physician-assisted dying to eligible patients if certain criteria were met: see *Baxter v Montana*, Supreme Court of Montana, 224 P.3d 1211 (2009). However, the legislature has not enacted legislation in response the Supreme

and Luxembourg in 2009.[3] However, in more recent years there has been a rapid rise in the number of jurisdictions enacting VAD legislation. Between 2010 and 2020, 11 jurisdictions introduced some form of legally-sanctioned VAD.

The province of Quebec (Canada) and Canada legalised VAD in 2015 and 2016 respectively;[4] in Australia, the States of Victoria and Western Australia followed shortly after, enacting VAD legislation in 2017 and 2019 respectively;[5] in the USA, Vermont, California, Colorado, Washington D.C., Hawaii, Maine and New Jersey all enacted VAD legislation at different points in time throughout the decade, and now permit physician-assisted dying.[6] The common theme between these jurisdictions is recognition of the need to safeguard a voluntary request from some form of external pressure. This Part will proceed by considering each jurisdiction separately with an emphasis on these protective mechanisms, starting with recent reforms that have occurred in Australia.

Court's ruling, therefore voluntary assisted dying in Montana will not be considered here, as the focus of this thesis is on the legislative response to safeguarding a voluntary request for VAD.

[3] See Ministere de la Sante, *Euthanasia and Assisted Suicide: Law of 16 March 2009 — 25 Questions, 25 Answers,* 37-43 (June 2010) <https://sante.public.lu/fr/publications/e/euthanasie-assistance-suicide-questions-reponses-fr-de-pt-en/euthanasie-assistance-suicide-questions-en.pdf>.

[4] See Table 6.

[5] *VAD Act 2017* (Vic); *VAD Act 2019* (WA).

[6] See Table 6.

Table 6 – Overview of Legislative Requirements to Safeguard a Voluntary Decision

Jurisdiction & Legislation	Safeguards	Terms defined in Law Yes/No
Australia		
1. **Victoria, Australia** *Voluntary Assisted Dying Act 2017* (Vic)	1) The co-ordinating medical practitioner must be satisfied that the person is acting voluntarily and without coercion; 2) The consulting medical practitioner must be satisfied that the person is acting voluntarily and without coercion; 3) An eligible witness must certify that the person signing the declaration appeared to freely and voluntarily sign the declaration; 4) If the individual making the VAD request cannot sign it, then the witness who witnesses another person signing the written declaration on the patient's behalf must certify that the person making the declaration appeared to freely and voluntarily direct the other person to sign the declaration; 5) If a practitioner administration permit is authorised then the co-ordinating medical practitioner must assess that the person is acting voluntarily and without coercion when requesting administration of the VAD substance; 6) The witness who witnesses a person making an administration request and who witnesses the administration of the VAD substance must certify in writing that the person requesting access to VAD appeared to be acting voluntarily and without coercion; 7) The medical practitioner who administers the VAD substance must certify in writing that they are satisfied that the person in requesting access to VAD acted voluntarily and without coercion.	**No**

Jurisdiction & Legislation	Safeguards	Terms defined in Law Yes/No
2. **Western Australia, Australia** *Voluntary Assisted Dying Act 2019* (WA)	1. To be eligible to request VAD, the person must be acting voluntarily and without coercion; 2. Coordinating medical practitioner must determine that the person is acting voluntarily and without coercion; 3. If the coordinating medical practitioner cannot determine if the person is acting voluntarily and without coercion, then they must refer the person to a specialist for assessment; 4. Consulting medical practitioner must determine that the person is acting voluntarily and without coercion; 5. If the consulting medical practitioner cannot determine that the person is acting voluntarily and without coercion, then they must refer the person to a specialist for assessment; 6. Witness must certify on the written declaration for VAD that the person appeared to freely and voluntarily sign the declaration; 7. If the individual making the VAD request cannot sign it, then the witness who witnesses another person signing the written declaration on the patient's behalf must certify that the person making the declaration appeared to freely and voluntarily direct the other person to sign the declaration; 8. Prior to administering VAD, the coordinating medical practitioner must certify on the final review form that the person is acting voluntarily and without coercion; 9. The coordinating medical practitioner administering VAD must be satisfied at the time of administration that the person was acting voluntarily and without coercion and must certify this in writing; 10. The person who witnessed the administration of VAD must certify that the persons request appeared to be free and voluntary; 11. An eligible applicant may apply to the State Administrative Tribunal (WA) for a review of the decision that the person was acting voluntarily and without coercion performed at	**No**

Jurisdiction & Legislation	Safeguards	Terms defined in Law Yes/No
	the Coordinating medical practitioner's first assessment, the Consulting medical practitioner's assessment or the Coordinating medical practitioner's final review assessment,; 12. If the tribunal decides that the person is not acting voluntary and without coercion then the request is void.	
Europe		
3. **The Netherlands** *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*	1. Physician must hold the conviction that the request by the patient was voluntary; 2. A second independent physician must give his opinion that the request by the patient was voluntary.	**No**[1]
4. Belgium *Belgian Act on Euthanasia of 28 May, 2002*	1. The physician ensures that the request is voluntary and not the result of external pressure; 2. If patient is not expected to die in the near future then a second independent physician must examine the person to ensure that the request is voluntary.	**No**
5. Luxembourg *Law of 16 March 2009 on Euthanasia and Assisted Suicide*	1. A doctor must reach the belief that the patient's request for euthanasia or assisted suicide is voluntary and does not result from external pressure.	**No**
Canada		

[1] This Table only considers whether the terms have been defined in the text of the legislation. In the Netherlands, the Regional Euthanasia Review Committee provides some guidance on this point: see Chapter 9 for discussion.

Jurisdiction & Legislation	Safeguards	Terms defined in Law Yes/No
6. Canada *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), RSC 2016, c. 3, ss 1-11.*	1. A person is eligible to access MAiD if they have made a voluntary request that was not made as the result of external pressure; 2. Two independent medical practitioners and/or nurse practitioners must be of the opinion the request was voluntary and not the result of external pressure.	**No**
7. Quebec, Canada *An Act respecting end-of-life care,* SQ 2014, c. 2, ss 1-72.	1. The physician must make sure that the request is freely made, and ensure that the request in not the result of external pressure.	**No**
The United States of America		
8. California *End of Life Option Act,* HSC Div. 1, part 1.85, ss 443 - 443.22 (2015)	1. The attending and consulting physicians must determine that the person has voluntary made the request; 2. Mental health expert must confirm that the person is acting voluntarily if referred by either physician for assessment; 3. Attending physician must confirm with the patient privately that the request does not arise from coercion or undue influence; 4. Two adult witnesses must: (i) attest to the best of their knowledge and belief that the person has signed the request voluntarily and free from undue influence; and (ii) declare on the written request that the person is not acting under duress or undue influence.	**No**
9. Colorado *Colorado End of Life Options Act* (2016), C.R.S., Title 25, Art. 48 ss 101-123	1. Attending physician must determine that the individual has made the request voluntarily; 2. Attending physician must refer to consulting physician for confirmation that the person is acting voluntarily; 3. Attending physician must confirm with the individual privately that their request does not arise from coercion or undue influence by discussing their request with them privately.	**No**

Jurisdiction & Legislation	Safeguards	Terms defined in Law Yes/No
	4. Two witnesses must: (i) attest to the best of their knowledge and belief that the individual is acting voluntarily and not being coerced to sign the request; and (ii) declare that the person signing the request does not appear to be under duress, coercion or undue influence.	
10. District of Columbia *Death with Dignity Act 2016*, DCCC § 7-661.01—7-661.16	1. the attending and consulting physicians must determine that the patient has made the request voluntarily; 2. Two witnesses must: (i) attest to the best of their knowledge and belief that the that the person is acting voluntarily and is not being unduly influenced to sign the request; and (ii) must declare that the person does not appear to be acting under duress or undue influence.	**No**
11. Hawaii *Our Care, Our Choice Act 2018,* HRS 327L-1—327L-25	1. The attending and consulting physicians must determine that the patient is making the request voluntarily; 2. Two witnesses must: (i) attest to the best of their knowledge and belief that the patient is acting voluntarily and not being coerced to sign the request; and (ii) declare that the person does not appear to be acting under duress or undue influence in signing the request.	**No**
12. Maine *Maine Death with Dignity Act*, MRSA 22 §2140 1—25	1. The attending and consulting physicians must determine that the patient is making the request voluntarily; 2. Attending physician must confirm that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the	**No**

Jurisdiction & Legislation	Safeguards	Terms defined in Law Yes/No
	presence of any other individual, except for an interpreter, whether the patient is feeling coerced or unduly influenced; 3. Two witnesses must: (i) attest to the best of their knowledge and belief the person is acting voluntarily and not being coerced to sign the request; and (ii) declare that the person making and signing the request does not appear to be acting under duress or undue influence.	
13. New Jersey *Medical Aid in Dying for the Terminally Ill Act,* NJRS, § 26:16-1—20 (2019)	1. The attending and consulting physicians must determine that the patient has made the request voluntarily; 2. Two witnesses must: (i) attest to the best of their knowledge and belief that the patient is acting voluntarily; and (ii) declare that the person making and signing the request does not appear to be acting under duress or undue influence.	**No**
14. Oregon *Death with Dignity Act 1997*, ORS 127.800—127.897	1. The attending and consulting physicians must determine that the person has made the request voluntarily; 2. Two witnesses must: (i) attest that to the best of their knowledge and belief the patient is acting voluntarily, not being coerced to sign the request; and (ii) declare that the person did not appear to be acting under duress or undue influence in signing the request.	**No**
15. Vermont	1. Two physicians must determine that the patient had made the request voluntarily; 2. Two witnesses must:	**No**

Jurisdiction & Legislation	Safeguards	Terms defined in Law Yes/No
Patient Choice at End of Life 2013, 18 V.S.A, § 5281-5293	(i) affirm and attest on the patient's written request that the patient appeared to be free from duress and undue influence at the time the request was signed.	
16. Washington *Death with Dignity Act 2008*, RCW Title 70, c. 70.245.200—220	1. The attending and consulting physicians must determine that the patient has made the request voluntarily; 2. Two witnesses must: (i) attest that to the best of their knowledge and belief the patient is acting voluntarily and not being coerced to sign the request; and (ii) declare that the person making and signing the request does not appear to be under duress or undue influence.	**No**

Introduction

[8.10] Victoria and Western Australia are currently the only states in Australia that have operational VAD legislation. The *Voluntary Assisted Dying Act 2017* (Vic) came into force on 19 June 2019 and *Voluntary Assisted Dying Act 2019* (WA) became operational on 1 July 2021.[1] These legislation do not create an absolute right for individuals to access VAD, but rather establish a framework for individuals to request VAD if they satisfy the eligibility criteria and statutory safeguards. The key legislative safeguards under both VAD frameworks that aim to protect a voluntary decision are that the person must be 'acting voluntarily and without coercion'.[2] As Outlined in Table 6, examination of these key provisions is mandated at different stages of the VAD process; however, nuances are evident between Victoria and Western Australia's respective legislation. Therefore, for clarity, key provisions in these VAD laws will be considered separately.

Victoria: Acting voluntary and without coercion — pivotal requirements of a valid request under the Voluntary Assisted Dying Act 2017 (Vic)

[8.20] Under the *Voluntary Assisted Dying Act 2017* (Vic) ('*VAD Act* (Vic)'), ensuring that the person requesting VAD is acting voluntarily and without coercion requires assessment at different stages of the VAD process. When Victoria was considering

[1] Department of Health, 'Voluntary Assisted Dying', *Government of Western Australia* (Web Page, 3 April 2020) <https://ww2.health.wa.gov.au/voluntaryassisteddying>; Department of Health, 'Voluntary Assisted Dying' *Government of Western Australia* (Web Page, 1 July 2021) <https://ww2.health.wa.gov.au/voluntaryassisteddying?mc_cid=0e967d465b&mc_eid=64c9b9471d>; see *Voluntary Assisted Dying Act 2021* (Tas), which passed both Houses of Parliament on 22 April 2021. The Tasmanian law will come into force on a day to be proclaimed or 18 months after the Act received royal assent: see s 2; see *Voluntary Assisted Dying Act 2021* (SA).
[2] See Table 6

introducing VAD legislation, the Legal and Social Issues Committee's Inquiry into End of Life Choices viewed acting voluntarily and without coercion as a key safeguard for any forthcoming VAD legislation in Victoria.[3] This is well integrated in the *VAD Act* (Vic),[4] which is one of the most conservative VAD models in the world, with 68 protective mechanisms incorporated into the legislation.[5]

For instance, protection of a voluntary decision commences prior to the person even requesting VAD. A key feature of the *VAD Act* (Vic) prevents the health practitioner from initiating discussions or providing information on VAD to a patient, with contravention of this provision considered unprofessional conduct under the *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic).[6] The impetus behind this caveat was articulated in the Explanatory Memoranda for the bill,[7] where it was highlighted that this measure was taken to 'protect individuals who may be open to suggestion or coercion by registered health practitioners'.[8] This response is unique to any other VAD law, as the *VAD Act* (Vic) specifically recognises the powerful position medical practitioners are vis-à-vis the patient, and how, by virtue of their position, they may unintentionally undermine voluntariness. Thus, it is mandatory for discussions about VAD to be instigated by the patient themselves.

Moreover, consistent with this protective stance, the *VAD Act* (Vic) also goes to the extraordinary length of implementing mandatory notification provisions requiring

[3] Legislative Council Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, June 2016) xxi, xxvii, 225.
[4] See Table 6.
[5] See Ben White, Lindy Willmott, Eliana Close et al, 'Development of Voluntary Assisted Dying Training in Victoria, Australia: A Model for Consideration' (2020) *Journal of Palliative Care* 1; see also Ben White et al, 'Does the *Voluntary Assisted Dying Act 2017* (Vic) Reflect its Stated Policy Goals?' (2020) 43 *University of New South Wales Law Journal* 417.
[6] *Voluntary Assisted Dying Act 2017* (Vic) s 8(1)—(3) ('*VAD Act* (Vic)').
[7] Voluntary Assisted Dying Bill 2017 (VIC).
[8] Explanatory Memoranda, Voluntary Assisted Dying Bill 2017 (VIC) 2–3 ('EM VAD BILL').

registered health practitioners to notify the Australian Health Practitioner Regulation Agency ('AHPRA') if another health practitioner is engaging in conduct that is not in accordance with the law. For instance, a health practitioner must notify AHPRA if they form a

> belief on reasonable grounds that another registered health practitioner … who provides health services or professional care services to a person [and] in the course of providing those services to the person, initiating a discussion or attempting to initiate a discussion that is in substance about voluntary assisted dying. [9]

Furthermore, the *VAD Act* (Vic) sets out other circumstances that also give rise to mandatory notification to AHPRA, being that if a registered health practitioner suggests or attempts to suggest VAD to a person or offers to provide, or attempts to provide, VAD in a manner that is not in accordance with the *VAD Act* (Vic).[10] The law imposes strict disciplinary penalties for medical practitioners who fail to comply with the mandatory notification requirements, and this is considered unprofessional conduct, thus attracting professional disciplinary action.[11] Therefore, it is evident that the legislature have gone to extraordinary lengths to ensure that discussions regarding accessing VAD are indeed patient initiated.

To be eligible to receive VAD, two medical practitioners — the coordinating medical practitioner and the consulting medical practitioner — must be satisfied that the person is acting voluntarily and without coercion.[12] Furthermore, if the request is approved, then a written declaration for VAD must be signed by the person in the presence of two witnesses who must certify that the person making the request appeared to freely and

[9] *VAD Act* (Vic) s 75(1)(a)(i).
[10] Ibid ss 75(1)(a)(i), (ii), (b); see also ss 76, 77.
[11] Ibid s 75(2).
[12] Ibid ss 20(1)(c), 29(1)(c).

voluntarily sign the request.[13] However, the duties and obligation of witnesses is more onerous compared to other jurisdictions.[14] In addition to certifying that the person requesting VAD did so freely and voluntarily, the *VAD Act* (Vic) also requires that a witness must certify that the person when requesting administration of the VAD substance, and, when the substance was administered, was acting voluntarily and without coercion.[15] Furthermore, the co-ordinating medical practitioner who administers the VAD substance must also assess and certify that, when the VAD substance was administered, the person was acting voluntarily and without coercion.[16] Moreover, both the co-ordinating medical practitioner's certification and the witness' certification must be on the same form.[17]

The role of the witness in certifying that the person was acting voluntarily and without coercion at the administration stage is an important protection incorporated into of the *VAD Act* (Vic). To reflect the increased emphasis placed on safeguarding a voluntary decision, it is stated in the Explanatory Memoranda for the Voluntary Assisted Dying Bill (Vic) that if a witness is unable to certify on the practitioner administration form that the person requesting administration was doing so voluntarily and without coercion, then VAD has not been administered in accordance with the permit — as required under the law — which constitutes an offence and the co-ordinating medical practitioner may be liable to be imprisoned for life.[18] The rationale behind this measure was to reinforce parliament's strict position on ensuring that voluntariness remains well protected.[19] Therefore, the requirement to ensure that the person was acting voluntarily and without coercion does not cease after the request is approved, but must be examined up to the

[13] Ibid s 36(1)(a)(i).
[14] See Table 6.
[15] *VAD Act* (Vic) s 65(2)(a)(ii).
[16] Ibid s 66(1)(c).
[17] These requirements only apply to situations when the medical practitioner is authorised to administer the VAD substance and not to patients who can self-administer.
[18] EM VAD BILL 2017 (Vic) 23; see also *VAD Act* (Vic) s 83.
[19] EM VAD BILL 2017 (Vic), 23.

point of administration, if this form of administration is approved. However, despite the repeated reference to acting voluntarily and without coercion, clear legislative guidance regarding their definition has not been provided.

The key terms used throughout the legislation have not been defined. However, the Department of Health and Human Services Victoria released a publication designed to educate medical practitioners on instances where coercion may be present in a request for VAD.[20] For instance, factors that should put the medical practitioner on notice that the request may not be voluntary are when there is

> excessive deferment by patient to carer for answers, reassurance and explanation, carer talking over the top of patient and answering on their behalf, inconsistencies in patient's answers to questions from the doctor about suffering, disease experience and voluntary assisted dying in general.[21]

Furthermore, to strengthen assessment of coercion, the *VAD Act* (Vic) mandates that medical practitioners who want to provide VAD must, subject to meeting mandatory professional requirements, complete state-endorsed VAD training.[22] Mandatory VAD training was recommended by the Ministerial Advisory Panel convened to advise the Victorian Government on proposed VAD legislation.[23]

The mandatory training for medical practitioners was developed and delivered by a multi-disciplinary team (experts in law, medicine, bioethics, nursing and allied health)[24] with regular input from the Department of Health and Human Services and the Implementation

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[20] Health.Vic, *Voluntary Assisted Training for Medical Practitioners: Identifying Coercion*, Department of Health and Human Services Government of Victoria (Web Page, March 2019) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/medical-practitioner-training>.
[21] Ibid.
[22] *VAD Act* (Vic) ss 17, 26, 114; see also White, Willmott, Close et al (n 5).
[23] Ministerial Advisory Panel on Voluntary Assisted Dying, Government of Victoria (Final Report, July 2017) 5.
[24] White, Willmott, Close (n 5) 2.

Taskforce.[25] The training consists of nine modules. White, Willmott and Close et al, who were responsible for the development and delivery of the training, explain that the 'training is primarily focused on providing doctors with knowledge of their obligations under the legislation [and] additional resources in each module provide clinical guidance'.[26] Module 4 of the mandatory training is relevant to this discussion, as it provides information concerning how medical practitioners should undertake eligibility assessments in accordance with the law, and also 'contains clinical resources about decision-making capacity, coercion and elder abuse'[27] — fundamental protections built into the *VAD Act* (Vic) that aim to protect voluntariness.

Thus, it is clear that safeguarding a voluntary request is a pivotal requirement under the Victorian model, with protection of a voluntary decision mandated before discussions on VAD commenced. There is no definition of 'acting voluntarily and without coercion' in the legislation itself. It is evident that the *VAD Act* (Vic) has avoided use of undue influence as a key statutory safeguard, adopting terminology that may be more amenable to examination. Furthermore, the response to strengthening voluntariness safeguards is to educate practitioners on situations where it may be undermined. Whether the medical practitioner properly assessed these requirements and administered VAD in accordance with the law is determined retrospectively by the Voluntary Assisted Dying Review Board.

[25] Ibid.
[26] Ibid 3.
[27] Ibid.

Role of the Voluntary Assisted Dying Review Board under the *Voluntary Assisted Dying Act 2017* (Vic)

[8.30] Review of all requests for VAD is performed by the Voluntary Assisted Dying Review Board ('the Board') established under the *VAD Act* (Vic).[28] The Board is vested with wide functions and powers.[29] Of importance to this discussion is the function to monitor compliance with the statutory requirements set out in the legislation, which includes determination that the co-ordinating and consulting medical practitioners have ascertained that the person requesting VAD was acting voluntarily and without coercion.[30] The Board performs a retrospective review of all granted requests for VAD, meaning that compliance with the statutory requirements is determined after the VAD medication(s) has been dispensed or directly administered to the patient.[31] The Board does, however, play an important role in ensuring that administrative requirements have been met throughout the VAD process so that VAD permits can be granted without unnecessary delay.[32]

A unique feature of the *VAD Act* (Vic) is that a permit to administer or dispense VAD medication must be granted by the Secretary of the Department of Health and Human Services ('DHHS') who are independent of the Board.[33] The Secretary of the DHHS has the power to refuse a VAD permit if they are not satisfied that the request and assessment process has been complied with.[34] To ensure that the Secretary can efficiently review permits for VAD, the secretariat – separate from the Secretary – of the Board performs an

[28] *VAD Act* (Vic) s 92.
[29] Ibid s 93.
[30] Ibid s 93(1)(a).
[31] Voluntary Assisted Dying Review Board, Safe Care Victoria, 'Terms of Reference' (11 September 2019) 1.
[32] Safe Care Victoria, *Report of Operations: January—June 2020*, Voluntary Assisted Dying Review Board, 3 <https://www.bettersafercare.vic.gov.au/reports-and-publications> ('VAD Report January—June 2020 (Vic)').
[33] *VAD Act* (Vic) ss 49(2), (3).
[34] Ibid s 49(2)(b), (3).

administrative check of the forms that must be submitted at different stages of the request process.

The VAD process is best described as consisting of distinct stages: the first assessment stage, second assessment stage, final review stage, permit stage, and administration stage (where applicable).[35] The co-ordinating and consulting medical practitioners must forward copies of all relevant documentation to the Board at all stages, except the permit stage, where documentation is sent directly to the Secretary of the DHHS. For example, after performing the first assessment, the co-ordinating medical practitioner must forward the First Assessment Report Form to the Board within seven days, informing the Board of the outcome.[36] The same procedure is mandated for the consulting medical practitioner, who must forward a copy of the Consulting Assessment Report Form.[37] Prior to requesting an administration permit to prescribe VAD, the co-ordinating medical practitioner must perform a final review of the person's final request for VAD, and, upon completion of the review, must send the Final Review Form to the Board within seven days.[38] Finally, if the co-ordinating medical practitioner is authorised to administer the VAD substance to the person, then they must forward to the Board a copy of the Practitioner Administration Form within seven days of administration.[39] Whilst it is apparent that that Board has an active role in ensuring that all the administrative requirements are met, and any issues are readily identified that may hinder a permit being granted, their role at this time is largely administrative. Determination of whether

[35] For the purpose of this discussion, the VAD process was limited to five stages. For information concerning other important stages: see *VAD Act* (Vic) s 6; VAD Report January—June 2020 (Vic).
[36] *VAD Act* s 21(2) sch 1, Form 1.
[37] Ibid s 30(2) sch 2, Form 2.
[38] Ibid s 41(2).
[39] Ibid s 66(2). If the patient has been authorised self-administration permit, once the medication has been prescribed, the pharmacist must forward a copy of the VAD dispensing form to the Board: ibid s 60(2).

VAD has been performed in accordance with the law is not ascertained until after the person has died.[40]

Compliance with the statutory requirements is determined by examining the prescribed forms and relevant documentation forwarded to the Board. The Board's power is limited in cases where it has been determined that the legal criteria have not been met. It has no power to sanction or penalise medical practitioners for non-compliance.[41] Instead, it must refer to the relevant authority for investigation and imposition of penalties.[42] The Board can, however, request a person to appear before it to give information to assist it in making a determination regarding compliance with the law.[43]

To date, the Board has published three activity reports on VAD, covering the period the Act came into force up until December 2021.[44] During this time, only one case of non-compliance has been reported. Whilst it was determined that the person was eligible to receive VAD, the co-ordinating medical practitioner failed to adhere to a procedural

[40] For further information on the administrative role of the Board and the percentage of incomplete forms, see VAD Report January—June 2020 (Vic) (n 32) 11-2.
[41] Safe Care Victoria, *Report of Operations: June to December 2019*, Voluntary Assisted Dying Review Board, 5 <https://www.bettersafercare.vic.gov.au/reports-and-publications/voluntary-assisted-dying-report-of-operations-june-to-december-2019> ('VAD Report June—December 2019 (Vic)').
[42] *VAD Act* (Vic) s 104.
[43] Ibid s 103.
[44] Only two activity reports – the VAD Report June—December 2019 (Vic) (n 41) 5 and the VAD Report January—June 2020 (Vic) (n 32) – will be considered here. The first activity report only covered the first 11 days of operation and no information was provided concerning requests for VAD see Safe Care Victoria, *Report of Operations: 2018*-2019 (online, 27 August 2019) <https://www.bettersafercare.vic.gov.au/publications/VADRB-2018-19#goto-download>; The July—December 2021 Report of Operations was not considered here as it was published on 25 February 2021 after the cut of date for consideration of new research for discussion see Safe Care Victoria, *Report of Operations: July–December 2020*, Voluntary Assisted Dying Review Board <https://www.bettersafercare.vic.gov.au/reports-and-publications/voluntary-assisted-dying-report-of-operations-july-to-december-2020> ('VAD Report July—December 2021 (Vic)'). The latest report, however, shows an increase in cases of non-compliance although there were no referrals to AHPRA: see 14. Although the Board does not have the power to penalise health practitioners for non-compliance, it can exercise its discretion in determining whether to forward an issue for investigation by another body, such as AHPRA see *VAD Act* s 93(1)(e)(v). The failure to forward the above cases of non-compliance seems very contrarian to their stated low-tolerance threshold for errors and non-compliance with the law: see VAD Report July—December 2021 (Vic) 14 It is not possible to develop this argument due to limited information available.

requirement and the case was referred to the AHPRA for further investigation.[45] Highlighting its strict position on ensuring that the statutory safeguards are met, the Board stated that it 'has a very low threshold for errors and inconsistencies in applications … while some may view these errors or inconsistencies as minor or trivial, [VAD] is a very serious matter'.[46] However, the *VAD Act* (Vic) exculpates medical practitioners from civil and/or criminal liability and professional disciplinary action for certain unauthorised acts. Under that legislation, if a medical practitioner performs an act in good faith and without negligence, 'believing on reasonable grounds that the act is in accordance in the Act [*VAD Act* (Vic)],' even though it is not, then they are granted immunity from penalty.[47] Thus providing some room for minor errors without fear of being subjected to civil and/or criminal liability or professional sanction. Further discussion regarding the breadth of this immunity — in particular, how it relates to assessment of acting voluntary and without coercion — is not possible as this is yet to be considered by the Board.

Thus, it is evident that the Board is willing to refer non-compliance with minor procedural aspects of the *VAD Act* (Vic) to the appropriate body. Ensuring that the person is acting voluntarily and without coercion are substantive safeguards under the law, and failure to properly assess the voluntariness of a request would constitute a breach of the law. However, as explained in the preceding paragraph, the medical practitioner may be indemnified from liability if it is deemed they acted in good faith and without negligence. It is not possible to engage in further discussion on how the Board examines these pivotal requirements, due to the limited time VAD has been operational in Victoria. However, based on this review of procedure, it can be said that, at the very least, ensuring that the

[45] VAD Report January—June 2020 (Vic) (n 32) 17.
[46] Ibid 14.
[47] *VAD Act* (Vic) s 80.

medical practitioner has turned their mind to the voluntariness of the request is examined at different stages of the VAD process — in some cases, up to the point of administration.

Interpretation of 'acting voluntarily and without coercion'

[8.40] In the activity reports released to date there has been no discussion on how the Board will determine that either the co-ordinating medical practitioner, the consulting medical practitioner, or the witnesses satisfactorily assessed that the person requesting VAD was acting voluntarily and without coercion.[48] No instances of non-compliance with this criterion have been identified. Additionally, discussion regarding the scope of these terms — that is, what behaviour would be sufficient to constitute coercion and abrogate the voluntariness of the request — cannot be provided at this stage. However, it is evident that the Victorian model has avoided the use of complex legal terms, such as 'undue influence', as a standard safeguard for a voluntary choice and instead incorporated potentially straightforward, non-legal terminology to achieve this objective. Whether the preferred tests adopted in Victoria will sufficiently identify requests where voluntariness is being undermined remains to be seen and will likely become clearer once VAD has become a developed practice in Victoria.

Western Australia: 'Acting voluntary and without coercion' — pivotal requirements of a valid request under the *Voluntary Assisted Dying Act 2019* (WA)

[8.50] The *Voluntary Assisted Dying Act 2019* (WA) ('*VAD Act* (WA)') was largely modelled on the *VAD Act* (Vic), although there are some points of difference to respond to the needs

[48] See VAD Report June—December 2019 (Vic) (n 41) 5; VAD Report January—June 2020 (Vic) (n 32).

of the Western Australian community.[49] Relevant to this discussion is the legislative response to safeguarding a voluntary decision. As outlined in Table 6, Western Australia has adopted the same terminology as Victoria concerning safeguarding a voluntary request — that is, the person requesting VAD must be acting voluntarily and without coercion. In fact, the procedure under the *VAD Act* (WA) is near identical to the Victorian model, with an important difference being that eligible applicants in Western Australia can apply to the State Administrative Tribunal (WA) ('the Tribunal') for review of the medical practitioner's decision regarding whether the person requesting VAD was acting voluntarily and without coercion.[50] If the tribunal decides that the person was not acting voluntarily and without coercion, then the request is void.[51]

The policy intent behind involving the Tribunal where there are reservations concerning voluntariness was an added safeguard 'to ensure that people are making a voluntary and valid decision to access [VAD] and that this decision is not subject to coercion'.[52] Indeed, the requirement to protect persons from coercion in requesting VAD is central to the operation of the *VAD Act* (WA), and is included as one of the core principles and eligibility criteria. In the Principles section of the Act, it is stated that 'there is a need to protect persons who may be subject to abuse or coercion',[53] which is reinforced by the inclusion of s 16(1)(e) of the *VAD Act* (WA) where 'acting voluntarily and without coercion' is a condition of eligibility, thus reinforcing the position that safeguarding voluntariness is a central objective.[54]

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[49] Western Australia, *Hansard,* Legislative Council, 26 September 2019, 3 (Stephen Dawson, Minister for Environment); Western Australia, *Hansard,* Legislative Assembly, 7 August 2019, 3 (Roger Cook, Minister for Health).
[50] *Voluntary Assisted Dying Act 2019* ss 84(1)(a)(iii), (1)(b)(iii), (1)(c)(ii) ('*VAD Act* (WA)').
[51] Ibid ss 88(f), 90.
[52] Joint Select Committee on End of Life Choices, Parliament of Western Australia, *My Life, My Choice* (Report 1, August 2018) xii ('JSC ELC (WA)').
[53] *VAD Act* (WA) s 4(1)(j).
[54] Explanatory Memoranda, Voluntary Assisted Dying Bill 2019 (WA) 5.

Consistent with the position in Victoria, medical practitioners cannot initiate discussions on VAD.[55] Penalties for contravening this provision is considered professional misconduct or unprofessional conduct under the *Health Practitioner Regulation National Law 2010* (WA) or unreasonable conduct under the *Health and Disability Services (Complaints) Act 1995* (WA).[56] Furthermore, medical practitioners cannot provide VAD until they have completed the state-mandated VAD training,[57] which is being developed and delivered by the Queensland University of Technology, also responsible for delivering training on VAD to medical practitioners in Victoria.[58] Additional training for medical practitioners, especially in the areas of assessment of decision-making capacity, voluntariness and identifying coercion, were viewed by the Joint Committee on End of Life Choices as pivotal requirements for any subsequent VAD legislation introduced into the Parliament of Western Australian.[59]

Determination of whether the person requesting VAD is acting voluntarily and without coercion requires assessment by two medical practitioners, with the second assessment provision only enlivened if the person satisfies the first stage of assessment. In each assessment, the medical practitioner — referred to as the co-ordinating and consulting medical practitioner under the Act — must make a clear determination in respect of this criterion.[60] If either practitioner is unable to determine that the person is acting voluntarily and without coercion, then they can refer the person to a specialist medical

[55] *VAD Act* (WA) s 10.
[56] Ibid ss 10(5), 10(6), 10(7).
[57] Ibid ss 25, 36.
[58] Government of Western Australia, 'Voluntary Assisted Dying Act 2019 Implementation Update' *Department of Health* (Pdf, 18 December 2020) 3 < https://ww2.health.wa.gov.au/voluntaryassisteddying>.
[59] JSC ELC (WA) (n 52) 96–7.
[60] *VAD Act* (WA) ss 24(1), 24(2), 35(1), 35(2)

practitioner who has expertise in this area.[61] Once the first and second assessments have been completed, the medical practitioner performing the assessment must notify to the Voluntary Assisted Dying Review Board ('the Board') — established under the law[62] — of the outcome of the assessment.[63] If the person has been deemed eligible by the co-ordinating and consulting medical practitioners, then they are eligible to make a written declaration for VAD, where they must declare that they are acting voluntarily and without coercion.[64] Furthermore, two witnesses must certify that the person appeared to sign the declaration freely and voluntarily.[65] After these steps have been satisfied, the person may then make a final request for VAD if nine days have elapsed since making the first request.[66]

Once these steps have been satisfactorily completed, the co-ordinating medical practitioner must then perform a final review of the request, including a mandated additional determination that the person was acting voluntarily and without coercion.[67] Following this, if the co-ordinating medical practitioner is permitted to administer the VAD substance to the patient, then they must again make a final determination at the time of administration that the person is still acting voluntarily and without coercion.[68] Furthermore, administration must be done in the presence of a witness who must also certify that the person's request appeared to free and voluntary.[69] Therefore, it is evident that ensuring that a request for VAD was made voluntarily and without coercion was important to this legislature as these issues must be examined multiple times. In cases

[61] Ibid ss 26(3), 37(3).
[62] Ibid s 116.
[63] Ibid ss 29(2), 40(2).
[64] Ibid s 42.
[65] Ibid s 44(2)(a). This declaration must be forwarded to the Board by the co-ordinating medical practitioner: see ibid s 46.
[66] Ibid s 48(1). There are exceptions to this rule: see ibid s 49. Furthermore, documentation concerning the final request must be forwarded to the board: see ibid s 50.
[67] Ibid s 51(3)(f)(ii).
[68] Ibid s 59(5)(b).
[69] Ibid s 62(3)(a).

where the patient is self-administering the VAD substance, there is no such requirement for the co-ordinating medical practitioner or witness to undertake this final assessment. However, consistent with the emphasis placed on ensuring that VAD is completely voluntary, it is an offence to induce a person by dishonesty, undue influence or coercion to either request or access VAD or to self-administer the VAD medication, with the penalty being life imprisonment.[70] The criminalisation of undue influence is the only introduction to undue influence in the entire *VAD Act* (WA).

It is clear that safeguarding a voluntary request is a pivotal requirement and must be examined multiple times, with protection of a voluntary decision evident even before discussions on VAD have commenced. There is no definition of 'acting voluntarily and without coercion' in the legislation itself. The response to this appears to be consistent with Victoria, which is to educate medical practitioners on situations where voluntariness may be undermined.[71] Whether the medical practitioner properly assessed these requirements is determined by the Voluntary Assisted Dying Board established under the law.

Role of the Voluntary Assisted Dying Board under the *Voluntary Assisted Dying Act 2019* (WA)

[8.60] The Voluntary Assisted Dying Board ('the Board') is established to, amongst other things, review requests for, and monitor VAD, in Western Australia.[72] It is not yet clear how the Board will perform review of requests — that is, whether the review will be retrospective where compliance is determined after death, as is the case in Victoria and

[70] *VAD Act* (WA) ss 100, 101.
[71] See Ministerial Expert Panel on Voluntary Assisted Dying, Government of Western Australia (Final Report, 2019) 96—100 ('Expert Panel (WA)').
[72] *VAD Act* (WA) ss 116, 118.

other jurisdictions or whether there will be ongoing assessment and monitoring. However, it is likely that the Board will have an active role throughout the VAD process due to the fact that the medical practitioner is required to forward relevant documentation to the Board after each assessment stage.[73] The intent behind the Board being routinely notified of the progress of the VAD request and the outcome of each assessment was to ensure that 'the correct process is being followed in each case of [VAD], and to maintain complete and accurate statistics of participation in [VAD] in Western Australia',[74] which would imply an ongoing review process rather than an entirely retrospective one. Additionally, consistent with the position in Victoria, the Board must publish an annual report on VAD which must include, inter alia, statistical information about individuals who request and receive VAD.[75]

It is not possible to engage in further discussion of the role of the Board in reviewing requests and how it will determine that the medical practitioner and witnesses properly assessed the voluntariness of the request. An 18-month implementation phase was recommended after the *VAD Act* (WA) received assent, so that the Western Australian Government would have ample time to 'plan, consult on and develop guidelines and protocols to ensure that the legislation is translated safely, effectively and appropriately for Western Australia''[76] The Act is set to come into force in mid-2021, with further information regarding implementation of VAD available in 2021.[77]

Interpretation of 'acting voluntarily and without coercion'

[73] See Expert Panel (WA) (n 71) 92–95.
[74] Western Australia, *Hansard,* Legislative Assembly, 7 August 2019, 11 (Roger Cook, Minister for Health).
[75] *VAD Act* (WA) ss 155(2)(f), 152.
[76] Expert Panel (WA) (n 71) 101–102.
[77] Government of Western Australia, *Voluntary Assisted Dying*, Department of Health (Web Page, 24 September 2020) <https://ww2.health.wa.gov.au/voluntaryassisteddying>.

[8.70] At the time of writing, information regarding how these criteria will be assessed has not been released; therefore, it is not possible to engage in detailed discussion on this point. It is evident that ensuring that persons requesting VAD are doing so of their own free choice is entrenched in the legislation. Moreover, the *VAD Act* (WA) has avoided the use of undue influence as a standard safeguard for a voluntary choice and instead incorporated straightforward terminology to achieve this objective.

Summary

[8.80] Victoria and Western Australia have now joined a select handful of jurisdictions to permit VAD. It is evident that these Australian jurisdictions have avoided using undue influence as a key statutory safeguard and have instead adopted straightforward language that is not embedded in the law. However, there is a lack of discussion concerning the definition of key terminology that aims to protect a voluntary decision. In these jurisdictions, VAD is still in its infancy. At the time of writing, the *VAD Act* (Vic) is nearing its third year of operation, whilst the *VAD Act* (WA) only commenced operation on 1 July 2021. Therefore, it remains to be seen whether issues will arise concerning the approach to safeguarding a voluntary request or whether amendments will be introduced to tighten the existing approach to safeguarding against external pressure. Although the discussion of VAD in these two jurisdictions was truncated, these developments represent a drastic shift in the way we think about end-of-life care. As VAD becomes a more entrenched practice in Victoria and Western Australia, more information may come to light regarding any shortcomings with the approach to protecting the voluntariness of decision-making for VAD.

Voluntary, free from duress, coercion and undue influence: Pivotal requirements for lawful physician assisted dying in the United States of America

[9.10] At the time of writing, nine jurisdictions throughout the United States of America ('US jurisdictions') have enacted legislation permitting physician assisted dying ('PAD'), subject to certain conditions.[1] Law reform in the US jurisdictions has been anything but consistent, with legalisation occurring sporadically over the past 25 years. It is interesting to note though that the majority of these nine jurisdictions only enacted PAD legislation in the last five years, demonstrating an increasing acceptance of PAD.[2] Although there is a recent growth in popularity, the legislative criteria across the US jurisdictions are similar.[3] The separate legislative frameworks grant physicians immunity from civil

[1] There are potentially 11 Jurisdictions in the United States of America that permit physician assisted dying ('PAD'). However, this thesis focusses on jurisdictions that have enacted legislation to regulate and control the provision of PAD. The remaining two US jurisdictions, Montana and North Carolina, have not enacted PAD legislation, and will not be examined in detail. On 31 December 2009, the Supreme Court of Montana ruled in *Baxter v Montana*, Supreme Court of Montana, 224 P.3d 1211 (2009) ('*Baxter*') that physicians could lawfully provide PAD to eligible patients if certain criteria were met. However, the legislature have chosen not to enact PAD legislation in response to *Baxter*. It is also necessary to note that some experts have remarked that the state of North Carolina indirectly permits PAD. However, no statute is operational in North Carolina and the lawfulness of PAD is uncertain. Therefore, North Carolina too falls outside the narrow scope of this thesis. For further discussion, see John Carbone et al, 'Aid in Dying in North Carolina' (2019) 80(2) *North Carolina Medical Journal* 128; Thaddeus Mason Pope, 'Medical Aid in Dying: Key Variations Among U.S. State Laws' (2020) 14(1) *Journal of Health and Life Sciences Law* 25.

[2] See Thaddeus Mason Pope, 'Medical Aid in Dying: Key Variations Among U.S. State Laws' (2020) 14(1) *Journal of Health and Life Sciences Law* 25, 26, who notes that PAD is now available to approximately 25% of the US population.

[3] Whilst the legislative frameworks adopted throughout the US Jurisdictions are largely similar, slight differences are evident regarding some substantive and procedural safeguards, with the most notable differences evident in Hawaii: see Mara Buchbinder and Thaddeus M. Pope, 'Medical Aid in Dying in Hawaii: Appropriate Safeguards or Unmanageable Obstacles?' *Health Affairs* (Blog, 13 August 2018) <https://www.healthaffairs.org/do/10.1377/hblog20180808.14380/full/>. For further discussion on the history of PAD in the USA, including variations among the legislation, see Thaddeus Mason Pope, 'Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures' (2018) 48(2) *New Mexico Law Review* 267; Pope '(n1) Compassion and Choices, Our Accomplishments (Web Page, 2020) <https://compassionandchoices.org/about-us/our-accomplishments/>. On 22 January 2021, Senate Bill 323 was introduced into the Hawaii Senate proposing to relax several of the safeguards in the *OCOCA* (Hawaii): see A Bill for an Act Relating to Health, SB 323, 31st Legislature (2021); see also Michael Cook, 'Hawaii Seeks to Liberalise Assisted Dying two Years after Legalisation' *BioEdge* (31 January 2021) <https://www.bioedge.org/bioethics/hawaii-seeks-to-liberalise-assisted-dying-two-years-after-legalisation/13683>.

liability, criminal prosecution and professional disciplinary action if they act in good faith when prescribing a PAD medication.[4] Additionally, one consistent shared characteristic relevant to this discussion is recognition of the need to safeguard a voluntary decision, with each state requiring voluntariness to be protected, with some emphasis placed on protection against undue influence.[5]

In comparison with the other jurisdictions discussed so far, there are several notable distinguishing features operational in the US jurisdictions. For instance, only patient administration of the lethal substance is lawful. The law across the US jurisdictions is clear and explicitly excludes physician administration of the lethal medication in all jurisdictions.[6] Furthermore, the US jurisdictions use distinct terminology — duress, coercion and undue influence — to safeguard a voluntary request. It is on this last point that striking similarities with past South Australian bills are evident, as both place a positive obligation on witnesses, and in some instances physicians, to assess for elements

[4] See *Death with Dignity Act 2016*, DCCC § 7-661.11(a) ('*DDA* (DC)'); *End of Life Option Act*, HSC Div. 1, part 1.85 443.14(b), (c), 443.16(c) ('*ELOA* (California)'); *Colorado End of Life Options Act* (2016), CRS, 25-48-116 ('*ELOA* (Colorado)'); *Our Care, Our Choice Act,* HRS §327L-19 ('*OCOCA* (Hawaii)'); *Death with Dignity Act*, ORS 127.885 §4.01(1) ('*DDA* (Oregon)'); *Medical Aid in Dying for the Terminally Ill Act,* NJRS, § 26:16(17)(a)(1) ('*MAID Act* (NJ)'); *Death with Dignity Act*, RCW Title 70, c. 70.245.190(1)(a) ('*DDA* (Washington)'). Under Vermont's PAD statute, the terms 'good faith compliance' have been omitted: see *Patient Choice at End of Life*, 18 VSA, §5283 ('*PCEL Act* (Vermont)'). Furthermore, this provision has been entirely omitted in the *Maine Death with Dignity Act*, MRSA 22 §2140(20) ('*DDA* (Maine)'), with the law instead explicitly stating that 'nothing in this Act may be interpreted to lower the applicable standard of care of physicians who participate in the Act'. It is, therefore, unclear what steps are taken if a physician contravenes the legislative criteria. Furthermore, under the *ELOA* (California) a physician can be subject to disciplinary action for unprofessional conduct, including good faith contraventions of the law: see 443.(14)(c). The good faith compliance criterion has not been accepted uncritically. It has been argued that this requirement establishes a lower standard of medical practice. For critique of the good faith criterion under the *DDA Oregon*, see Herbert Hendin and Kathleen Foley, 'Physician Assisted Suicide in Oregon: A Medical Perspective' (2008) 24(2) *Issues in Law and Medicine* 121. As a potential response to this criticism, §2140(20) of the *DDA* (Maine) explicitly states that 'nothing in this Act may be interpreted to lower the applicable standard of care for the attending physician, the consulting physician or the psychiatrist …'; see also *MAID Act* (NJ) § 26:16-15(b).

[5] An overview of the legislative response to safeguarding a voluntary decision in each state is provided in Table 6.

[6] *DDA* (DC) § 7-661.15(a); *ELOA* (California) 443.18; *ELOA* (Colorado) 25-48-121; *OCOCA* (Hawaii) §327L-18(a); *DDA* (Maine) §2140(20); *DDA* (Oregon) 127.880 §3.14; *MAID Act* (NJ) § 26:16(15)(a); *PCEL Act* (Vermont) §5292; *DDA* (Washington) 70.245.180(1).

of undue influence in a request without defining it or explicating how assessment of undue influence can be performed.

For instance, under California's *End of Life Option Act* ('*ELOA* (California)'), witnesses are required to declare that they believe the person signing the request is not acting under undue influence.[7] Furthermore, the attending physician ('AP') is duty bound to

> [c]onfirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person.[8]

Table 6 provides an overview of the legislative requirements that aim to safeguard a voluntary request from undue influence in each of the US jurisdictions. Given the absence of significant variation between the legislative responses, the relevant legal provisions will be discussed together. However, when relevant, key differences will be highlighted.[9] The following discussion will outline the AP and witnesses' respective legislative duties to safeguard against undue influence.

The attending physician's duty to safeguard against undue influence

[9.20] Of the nine US jurisdictions that have enacted PAD legislation, only California, Colorado and Maine place a positive obligation on the AP — the physician who prescribes

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[7] *ELOA* (California) 443.5(a)(4).

[8] Ibid 443.5(a)(4). This is similar to the position adopted under the Death with Dignity Bill 2016 (SA) for instance, two medical practitioners were required to assess for elements of undue influence in a request for voluntary VAD. If either suspected that the person making the request was acting under undue influence, then they had to refer the person for 'evaluation by a psychiatrist to confirm or deny the suspicion'.[8] Moreover, two witnesses were required to certify that they were of the opinion that the person was not acting under undue influence in relation to their request see Death with Dignity Bill 2016 (SA) s 14(1)(c)(v). No steps were taken to define undue influence in either the *ELOA* (California) or the Death with Dignity Bill 2016 (SA). For a comparative analysis of the legislative response to safeguarding against undue influence, see Table 5 and Table 6.

[9] For broader discussion on key differences amongst the laws in the US jurisdictions, see Pope (n 1).

or dispenses the medication — to actively assess whether the person is acting under undue influence in requesting PAD.[10] This screening for undue influence operates in conjunction with the AP's obligation to ensure that the person is making the request voluntarily, a rudimentary safeguard in all US jurisdictions. Prior to granting a request for PAD, the AP must ensure that the patient is acting voluntarily.[11] Furthermore, it is compulsory for the AP to refer the patient to a consulting physician ('CP') to verify the voluntary nature of the request.[12] Neither term has been defined in the legislation, nor any regulatory instrument issued under the law.[13] However, by including screening for

[10] *ELOA* (California) 443.5(a)(4); *ELOA* (Colorado) 25-48-106(1)(g)*; DDA* (Maine) §2140(6)(E).
[11] *ELOA* (California) 443.1(a)(1)(C); *ELOA* (Colorado) 25-48-106(1)(a), (1)(d); *DDA* (DC) § 7-661.03(a)(1)(C); *OCOCA* (Hawaii) §327L-4(a)(1); *DDA* (Maine) §2140(6)(A); *MAID Act* (NJ) § 26:16(6)(1); *DDA* (Oregon) §3.01(a); *PCEL Act* (Vermont) §5283(a)(5)(D); *DDA* (Washington) 70.245.040(1)(a). In Colorado, the AP must refer the patient to a consulting physician for verification that, inter alia, the patient is making the request voluntarily. However, under s 25-48-107 *ELOA* (Colorado), there is no requirement for the CP to verify that the person is making the request voluntarily: see Table 6. It is, therefore, evident that there is an anomaly in the Act.
[12] *ELOA* (California) s 443.6(c); *ELOA* (Colorado) 25-48-106(1)(d); *OCOCA* (Hawaii) §327L-5; *DDA* (DC) § 7-661.03(b)(1)(B); *DDA* (Maine) §2140(7); *MAID Act* (NJ) § 26:16(7)(c); *DDA* (Oregon) 127.820 § 3.02; *PCEL Act* (Vermont) §5283(a)(7); *DDA Act* (Washington) 70.245.050.
[13] The absence of a general definition of 'voluntary' is concerning as well, especially as this is a foundational element of a valid request for PAD in all US jurisdictions. Guidance and clarity on this point is likely to result in greater diligence when examining the voluntariness of a request. This is especially pertinent in circumstances where there is no pre-existing physician-patient relationship, which is not required under the law. Therefore, relationships solely confined to the provision of PAD are permitted: see Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2019 Data Summary' *Oregon Health Authority* (pdf, 6 March 2020) 12 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>. However, it has been observed that the corresponding obligation on physicians when determining that the patient is 'acting voluntarily' is to ensure that the patient is choosing freely, according to their own free will, without constraint or pressure from others. When the *DDA* (Oregon) commenced operation in 1997, a multi-disciplinary task force was convened by the Center for Ethics in Health Care, Oregon Health and Science University. The mandate of the task force was to provide practical guidance on all aspects of the Oregon law — including assessment of voluntariness — to physicians who elected to participate in the *DDA* (Oregon). The resulting publication was the *Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* see Patrick Dunn et al, *Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* (Task Force to Improve the Care of terminally Ill Oregonians, 2007) ('the Guidebook'). Whilst the Guidebook stops short of providing a working definition of 'acting voluntary' or the like, the authors explore the voluntariness safeguards, supporting the preceding explanation describing voluntary as being a decision made free from external constraint or pressure from others. The Guidebook remarks that 'doubts concerning the patient's … volition should be resolved against provision of medication [and] that attending and consulting physicians should also take care to document an awareness of the patient's broader circumstances and a sensitivity to any indication that the patient's request is coerced or the product of the undue influence of family, friends, or others' [15]. The Guidebook, however, has no legal status and only operated to inform physicians of best practice when participating in the *DDA* (Oregon). it is clear though that the authors have gone further than the statute by including freedom from undue influence as part of the voluntary examination, although the *DDA* (Oregon) is silent on the breadth of this criterion and it is uncertain if screening for undue influence forms part of this assessment at law. Furthermore, the Guidebook does not

undue influence as an added layer of protection, it is evident that the legislature intended to provide greater protection of a voluntary decision.[14]

Under the *ELOA* (California), the *ELOA* (Colorado) and the *DDA* (Maine), undue influence has not been defined and it is unclear if further clarification has been provided to APs who must undertake this assessment. However, the obligation to assess for undue influence in a request for PAD is not limited to APs alone. The most consistent shared characteristic amongst the US jurisdictions is that witnesses are also called upon to safeguard against undue influence.

Witnesses' duty to safeguard against undue influence

[9.30] All US jurisdictions require two adult witnesses to assess for undue influence, with the corresponding obligation being that they must declare the person signing the written request for PAD is not acting under undue influence.[15] There is a slight variation between the laws regarding the degree of conviction required of witnesses, which has been highlighted in Table 6. It is not obligatory for either witness to be known to the person signing the request for PAD, although the law is explicit concerning persons who are ineligible to act as witnesses.

explore what is undue influence or whether there are any mandatory elements that must be considered. Notwithstanding this issue, it does provide some insight into factors that should be considered when ascertaining whether the patient's request for PAD is voluntary. However, it remains to be seen whether this interpretation of 'voluntary' has been adopted throughout all of the US Jurisdictions (even Oregon). This criterion has never been judicially considered, therefore further insight into the parameters of the requirement to ensure that the patient is 'acting voluntary' is not possible.

[14] See End of Life Option Act, ABx2 15, 2015-2016 Second Extraordinary Session, California Legislature (2015); 2015-2016 Second Extraordinary Sess., Assemb. Third Reading Deb., 11 (3rd Sept. 2015); 2015-2016 Second Extraordinary Sess., S. Rules Comm. Third Reading Deb., 10 (3rd Sept. 2015).

[15] These legislative requirements have been outlined in Table 6. For further discussion, see Pope '(n1).

For example, the *Oregon Death with Dignity Act* ('*DDA* (Oregon)')[16] stipulates that one witness must not:

- be related to the person by blood, marriage or adoption;
- have an interest in the estate of the person requesting PAD;
- be an owner operator or employee of a health care facility where the person is receiving treatment or residing there; or
- be the patient's AP.[17]

Similar restrictions are in place throughout all the US jurisdictions. Whilst the legal position is clear regarding who is ineligible to act as a witness, the legislative response concerning who can act as a witness, on the other hand, is liberal. For instance, there is no requirement for either witness be personally known to the individual making a request for PAD. In these situations, the requirement is that the person making the request for PAD must provide proof of their identity to the witness.[18] Furthermore, no jurisdiction has attempted to legislatively define undue influence or provide any guidance for witnesses who are called upon to undertake this examination. This raises specific challenges because how can one make a judgment regarding influence on an individual when they have no prior knowledge of them, their decision-making processes, or their normal demeanour.

No legislative definition of undue influence: the consistent legislative response

[16] *DDA* (Oregon) 127.810 §2.02(2)
[17] Ibid §2.02(2)(a), (b), (3).
[18] See *DDA Act* (DC) § 7-661.02(c)(a); *DDA* (Maine) §2140(24)(1); *DDA* (Oregon) 127.897 §6.01(a); *DDA* (Washington) 70.245.220 (1); *ELOA* (California) 443.3(b)(3)(A); *ELOA* (Colorado) 25-48-112(1); *MAID Act* (NJ) 26:16-20(1); *OCOCA* (Hawaii) § 327L-23(a); *DDA* (Maine) §2140(24)(1). The position under the *PCEL Act* (Vermont) differs and the legislation is silent on this point. Therefore, there is no requirement in Vermont for the person to either be personally known to the person making the request or to provide proof of identity to the witnesses.

[9.40] The doctrine of undue influence plays an important role in safeguarding a voluntary request for PAD, with witnesses called upon in all US jurisdictions to determine whether there has been undue influence. Furthermore, three states have taken an additional step and require APs to assess for undue influence in a request for PAD. However, whilst it is clearly an important consideration, no jurisdiction has defined what undue influence is and there appears to be a sustained silence surrounding this. This approach to undue influence is perplexing given:

1. its prevalence as a statutory safeguard;
2. the gravity of PAD; and
3. the historical origin of undue influence, firmly embedded in equity and the law.

Briefly expanding on Point 3, undue influence is historically a legal term.[19] It is a term of equitable origin and has its own legal definition. Furthermore, the judicial development of the doctrine has resulted in it being adopted into other areas of law, where its definition has been amended. Without any legislative definition or guidance, it is empty of any true meaning. Therefore, it is dubious whether protection against undue influence provides meaningful protection of a voluntary decision or has any salutary value.

It is not the focus of this thesis to critique the use of undue influence as a statutory safeguard in the US jurisdictions. The aim of Part 2 is to highlight the varied response to safeguarding a voluntary decision throughout the jurisdictions that have enacted VAD legislation, with a view to gain further insight into VAD laws in other jurisdictions, so this research can be used at a point of reference for South Australia. The statutory response to undue influence in the US jurisdictions is important to this discussion, as there are

[19] The history of undue influence will be considered in Part 3. However, for discussion of undue influence in the United States of America see *Re: The Estate of Barnes*, 185 Wn. 2d 1 (Wash, 2016); *Fielding v Tullos,* (Tex Ct App 9thD 743., No 09-17-00203-CV, 29 June 2018); *Existence of Illicit or Unlawful Relation Between Testator and Beneficiary as Evidence of Undue Influence*, 76 ALR 3d.

striking similarities to South Australia's proposed response to safeguarding against undue influence. It is likely that the Parliament of South Australia have been influenced — perhaps blindly — by the introduction of undue influence in the US jurisdictions and have followed the same path without critically examining how undue influence can be translated into an effective safeguard in practice. Given the silence and lack of legal consideration concerning undue influence, the validity of it as a protector for a voluntary decision is difficult to assess. It remains uncertain whether screening for undue influence is capable of providing meaningful protection of a voluntary decision. However, some insight into the legislative gap presented by the absence of a definition of undue influence can be found by looking beyond the literature on PAD and considering the use of undue influence as a statutory safeguard in the distinct area of probate law in California.

In the *California Probate Code*,[20] ('*CPC*')the absence of a statutory definition of undue influence was an issue of concern to probate lawyers. Stakeholders, not experts in the law on undue influence, were called upon to examine whether individuals, involved in an application of conservatorship of estate, were likely to be susceptible to undue influence.[21] This shortcoming resulted in a large-scale research project being undertaken by Quinn et al, supported by the Borchard Center on Law and Ageing, into definitions and applications of undue influence[22] with a view to amend the *CPC*.[23]

[20] *Probate Code,* PROB, divs 1–11, §§ 1–21700.
[21] See *Conservatorship*, PROB, div 4, pt 3, § 1801(b).
[22] Mary Joy Quinn et al, Undue Influence: Definitions and Applications: Final Report to the Borchard Foundation Center on Law and Ageing (March 2010) <https://www.elderjusticecal.org/undue-influence.html>.
[23] *Probate Code,* PROB, Div 1, Pt 2, § 86; *Elder Abuse and Dependent Adult Civil Protection Act,* WIC, div 9, pt 3, Ch 11, 15610.70; see also Mary Joy Quinn et al, 'Developing an Undue Influence Screening Tool for Adult Protective Services' (2017) 29(2)-(3) *Elder Abuse and Neglect* 157.

In March 2010, Quinn et al published their final report into definitions and applications on undue influence.[24] The impetus behind their project was to suggest amendment to the *CPC* to include a definition of undue influence, and, in response to the report, their recommendation was adopted in 2014. Prior to the 2014 amendment of the *CPC*, there was no definition of undue influence, although it was widely used as a ground to grant a conservatorship of an estate.[25] Quinn et al reported that the absence of a clear definition was a source of confusion for key stakeholders involved in conservatorship applications.[26] Furthermore, they remarked that the need for a working definition of undue influence was necessary as there was an upsurge in the reporting of elder abuse and neglect, and, incidentally, conservatorship applications alleging undue influence.[27] Thus, a clear definition of undue influence was necessary to facilitate consistency and clarity for:

1. the probate courts in assessing conservatorship of estate applications; and
2. those called upon to undertake an assessment of whether a person was unable to resist undue influence, which were largely public sector employees working in adult protective services.[28]

Whilst Quinn et al's research was limited to the area of probate, it could, nonetheless, be relevant to PAD, as parallels are evident regarding the statutory use of undue influence. In both probate and PAD, individuals who are not experts in the law on undue influence are called upon to determine whether undue influence is being exerted on an individual with whom they are unlikely to be acquainted with. Furthermore, the impetus behind safeguarding against undue influence is largely commensurate — both deriving from a position of protection from abuse. In conservatorship applications, screening for undue

[24] Quinn et al (n 26).
[25] *Conservatorship*, PROB, div 4, pt 3, § 1801(b).
[26] Quinn et al (n 26) 3–4.
[27] Ibid 4–5.
[28] See especially, Mary Joy Quinn et al, 'Developing an Undue Influence Screening Tool for Adult Protective Services' (2017) 29(2–3) *Journal of Elder Abuse and Neglect* 157.

influence is utilised to protect against financial elder abuse; whereas, in PAD, it is used to protect against unacceptable external pressure or influences that would vitiate a voluntary request for medication to end life. Yet, in the space of PAD, no effort has been made to define undue influence or provide guidance for witnesses and physicians called upon to undertake this assessment. Given that they are positioned as gatekeepers for questions of undue influence, greater clarity on undue influence should be mandated in the area of PAD. It is remarkable that the US jurisdictions would not utilise Quinn et al's research to attempt to strengthen protections against undue influence in PAD legislation.

In summary, it is evident that protection of a voluntary decision is a central legislative safeguard — one which must be medically confirmed and independently verified by witnesses. However, APs in California, Colorado and Maine carry a heavier burden than APs in the remaining US jurisdictions as they are under a positive obligation to confer with a patient privately to examine for elements of undue influence in their request for PAD. Similar to the obligations placed on APs in California, Colorado and Maine, witnesses are also required to assess for undue influence in a request, yet no attempt has been made to define undue influence in any of the US jurisdictions by statute, regulation or otherwise. The lack of clarity and guidance on this point questions whether these statutory protections against undue influence are capable of providing meaningful protection of a voluntary decision.

Another vital aspect of PAD legislation in the US jurisdictions is that all approved requests for PAD must be subjected to independent review to determine whether the AP complied with both the substantive and procedural legislative safeguards. Protection against undue influence is considered a substantive safeguard and assessment of whether the AP properly discharged their obligation to examine for undue influence in a request is

performed retrospectively — that is, after PAD has been authorised. Legalisation of PAD is a matter for the individual states in the United States of America. So too is the review procedure process, with each jurisdiction implementing its framework to monitor compliance with the law.

Review procedure in the US jurisdictions

[9.50] Compliance review in all of the US jurisdictions is performed retrospectively. For ease of reference, an overview of the review procedure process has been provided in Table 7.[29] Assessment of whether the AP properly determined that the request was voluntary and, where relevant, not the result of undue influence, is undertaken at this point. As shown in Table 7, the body responsible for compliance review in all states is the relevant state Department of Health or equivalent.[30] The function of the review bodies is, however, limited and they have no power to sanction physicians for allegations of non-compliance with the law.[31]

It has not been expressly stated in the legislation itself what steps are taken if the AP is deemed to be non-compliant with the law. In such cases, however, it has been indicated that the immunity from civil and criminal liability and professional disciplinary action is revoked, thus exposing the physician to professional risk, litigation and/or criminal prosecution.[32] To date, there is no evidence to suggest that a physician has ever been

[29] Table 7 is limited to an overview of review procedure that specifically relates to assessment of undue influence/voluntariness. Other forms (such as psychiatrist/psychologist compliance form and AP follow up forms) where required, have not been included.
[30] See Table 7.
[31] For further discussion on this requirement, see John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2nd ed, 2018) 345–76.
[32] See, eg, *DDA* (Oregon) 127.885 §4.01(1); see also '2009 Death with Dignity Act Report', *Washington State Department of Health* (pdf) 14 <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignit

subject to legal or professional sanction for non-compliance with the law — including failing to adequately examine for undue influence — although several physicians in Oregon have been referred to the Oregon Medical Board for non-compliance with the legislative criteria. In these cases, no further action was taken as they were deemed to have acted in good faith.[33]

In all US jurisdictions, it is the responsibility of the AP to submit all relevant documentation to the review body. This documentation must be forwarded within 30 days of authorising PAD,[34] except in Oregon and Vermont, where the respective requirement is to complete this step within seven days,[35] or 'promptly'.[36] Compliance with the law is determined by reviewing compliance forms and other documentation. However, there is some procedural variation amongst the US jurisdictions on this point. For instance, in Colorado, the AP must submit to the Department of Public Health and Environment:

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yData>; see also Vermont Department of Health, 'Report Concerning Patient Choice at the End of Life' (pdf, 15 January 2018) 3 <https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life>; see further Keown (n 34) 354–55.

[33] For further discussion, see **[9.60]**; see also Oregon.gov, Oregon's Death with Dignity Act, *Oregon Health Authority* (Web Page) <https://www.oregon.gov/oha/PH/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx>; see also Michaela Estelle Okninski, 'A Comparative Analysis of Voluntariness Safeguards and review Procedure under Oregon and the Netherlands' Physician Assisted Dying Laws' (2018) 41(1) *Dalhousie Law Review* 121. The Oregon Health Authority and the Oregon Medical Board were contacted directly by email to confirm whether disciplinary action was commenced against physicians who were referred to the Oregon Medical Board for non-compliance with the *DDA* (Oregon). It was confirmed that no disciplinary has ever been taken against a physician since the law went into force in 1997, up until the end of 2016: see Email from Michaela Estelle Okninski to Oregon Health Authority, 18 August 2017; Email from Oregon Health Authority to Michaela Estelle Okninski, 18 August 2017; Email from Michaela Estelle Okninski to Oregon Medical Board, 18 August 2017; Email from Oregon Medical Board to Michaela Estelle Okninski, 31 August 2017.

[34] See *DDA* (Maine) §2140(17)(B)(1); *DDA* (Washington) 70.245.150(b); *Death with Dignity Act Requirements,* WAC 246-978-001—040; *ELOA* (California) 443.9(b); *Reporting and Collecting Medical Aid-in-Dying Medication Information*, 6 CCR 1009-4-II(A); *MAID Act* (NJ) 26:16-13(1); *OCOCA* (Hawaii) § 327L-14(a). The requirement differs slightly in the District of Columbia as the AP must report to the Department of Health within 30 days of a healthcare provider dispensing a PAD prescription: see *DDA Act* (DC) § 7-661.05(e).

[35] *Reporting Requirements of the Oregon Death with Dignity Act*, OAR 333-009-0010(1) ('*Reporting Requirements Oregon*').

[36] *PCEL Act* (Vermont) §5283(15).

- the AP's Medication Reporting Form;
- the CP's written report; and
- a copy of the patient's written request for physician assisted dying.[37]

California, the District of Columbia, Hawaii, Maine, Oregon, Vermont, and Washington do not require the CP's written report and have instead drafted a compliance form where the CP must prove that they complied with the legal criteria.[38]

The compliance forms are drafted by the relevant state Department of Health and are available online.[39] For illustrative purposes, a copy of Oregon's compliance forms have

[37] See *Requirements for Reporting Medical Record Information to the Department*, 6 CCR § 1009-4-II(1), (1)(A)(4); Colorado Department of Public Health and Environment, *Medical Aid in Dying* (Web Page, 2021) <https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying#Reporting>.

[38] *ELOA* (California) 443.5(11); *DDA Act* (DC) §§7–661.07(a), 7–661.05(e); DC.gov, Death with Dignity Forms, *DC Health* (Web Page) <https://dchealth.dc.gov/node/1250671>; *DDA* (Maine) §2140(17)(C); Office of Planning Policy and Program Development, Our Care, Our Choice Act (End of Life Care Option), *State of Hawaii, Department of Health* (Web Page) <https://health.hawaii.gov/opppd/ococ/>; Maine.gov, Data, Research and Vital Statistics – Forms, *Division of Public health Systems* (Web Page, 2021) <https://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml>; *DDA (*Oregon) 127.865 §3.11(2); *Reporting Requirements of the Oregon Death with Dignity Act*, OAR(n 39) 333-009-0010(1)(a)-(d); NJ Health, Medical Aid in Dying, *Department of Health* (Web Page, 31 July 2020) <https://nj.gov/health/advancedirective/maid/>; Oregon.gov, Death with Dignity Reporting Forms and Instructions, *Oregon Health Authority* (Web Page) <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/pasforms.aspx>; Healthvermont.gov, *Patient Choice and Control at End of Life* (Web Page) <https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life>; *DDA (Washington)* 70.245.150(2); *Death with Dignity Act Requirements,* WAC, §246-978-020(1)(a)-(d); Washington State Department of Health, *Forms for Patients and Providers* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/FormsforPatientsProviders>.

[39] Ca.gov, End of Life Option Act, *California Department of Public Health* (Web Page, 4 September 2020) <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx>; CPDHE, Medical Aid in Dying, *Colorado Department of Public Health & Environment* (Web Page) <https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying>; State of Hawaii Department of Public Health, Our Care, Our Choice Act (End of Life Care Option), *Office of Planning Policy and Program Development* (Web Page, 2021) <https://health.hawaii.gov/opppd/ococ/>; DC.gov, Death with Dignity Forms, *DC Health* (Web Page) <https://dchealth.dc.gov/publication/death-dignity-forms>; Maine.gov, Data, Research and Vital Statistics Forms, *Division of Public Health Systems* (Web Page, 2021) <https://www.maine.gov/dhhs/mecdc/public-health-systems/data-research/vital-records/forms/index.shtml>; State of New Jersey, Medical Aid in Dying, Department of Health (Web Page, 31 July 2020) <https://www.nj.gov/health/advancedirective/maid/#3>; Oregon.gov, Death with Dignity Act Forms and Instructions, Oregon Health Authority (Web Page) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATH

been provided in Appendix 1. Unlike the position adopted in Belgium and Luxembourg, which are considered below at **[12.20]** and **[13.20]** respectively, anonymity is not a central feature of the review procedure and physicians must provide their personal information as well as the patient's[40] on the forms provided.[41] Furthermore, instead of being required to provide a detailed report to demonstrate how the legislative requirements were adhered to, the compliance forms require the AP and CP to tick a box indicating adherence to the substantive and procedural criteria. Some jurisdictions have provided additional space on the forms for the physicians to add comments, although this is a discretionary requirement and writing space is limited to a few lines, which arguably acts as a deterrent from providing more detailed information. The majority of the US jurisdictions review records annually;[42] however, Colorado and Oregon have limited review to a sample of records.[43] The review procedure adopted in the District of Columbia appears to be a two-stage process, with both the Office of the Chief Medical Examiner and the Department of Health responsible for reviewing each PAD death. Additionally, the Department of Health is authorised to conduct an investigation into a PAD death if they deem it necessary.[44] The grounds for undertaking such a review have not been articulated, therefore this appears to have broad application, vesting the Department of Health with wide discretionary power to launch an investigation into a PAD death.

WITHDIGNITYACT/Pages/pasforms.aspx>; Vermonthealth.gov, *Patient Choice and Control at End of Life* (Web Page, 2021) <https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life>; Washington State Department of Health, Forms for Patients and Providers (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/FormsforPatientsProviders>.

[40] Ibid.

[41] Belgium and Luxembourg are discussed in Chapters 12 and 13.

[42] *Death with Dignity Act DDA* (DC) §7-661.07(a); *ELOA* (California) 443.19(a), (b); *OCOCA* (Hawaii) §327L-14(c); *DDA* (Maine) §2140(17)(A); *Death with Dignity Act Reporting Rules*, CMR 10-146-015(4)(A)(4); *MAID Act* (NJ) 26:16-13; *PCEL Act* (Vermont) §5293(a); *Compliance with Patient Choice at the End of Life,* CVR 13-140-079(6); *DDA* (Washington) 70.245.150(1)(a).

[43] *ELOA* (Colorado) 25-48-111(2)(a); *DDA* (Oregon) 127.865 §3.11.

[44] *DDA* (DC) §7-661.05(e), (h)(i)(1); *Death with Dignity Regulations,* 64 DCMR 7276, 302.6.

Of importance to this discussion is that the AP and consulting physician are required to tick a box indicating that they determined that the patient was acting voluntarily,[45] and in California, Colorado and Maine, tick a box indicating that they actively assessed for undue influence in a request. There is no obligation for either physician to provide a detailed account of how they determined that the person was not being unduly influence; this information must, however, be documented in the patient's medical record.[46] Additionally, there is no obligation for the respective review bodies to independently verify that the witnesses called upon to examine for undue influence adequately discharged this obligation, and witnesses are only required to initial that the person requesting PAD appeared to not be acting under undue influence. Furthermore, witnesses are not required to defend how they ascertained that the person appeared to be acting free from undue influence. Therefore, not only do the US jurisdictions fail to define and attribute meaning to undue influence, it appears that they provide a perfunctory review of adherence to this criterion, limiting compliance review to a self-reported tick box standard.[47] The data collected from the compliance forms is not open for public inspection and there are protections in place to prevent this information from becoming publicly available.[48] However, the review bodies must release a statistical report, either annually

[45] Appendix 1 includes a copy to the Attending Physician's Compliance Form, the Consulting Physician's Compliance Form and the Patient's Written Declaration for Death with Dignity.
[46] *ELOA* (California) 443.8(c); *ELOA* (Colorado) 25-48-111(1)(c); *DDA* (DC) §7-661.06(a)(3)(B); *OCOCA* (Hawaii) §327L-12(3); *DDA* (Maine) §2140(14)(C); *MAID Act* (NJ) 26:16-10(d); *DDA* (Oregon) 127.835 §3.09(3); *PCEL Act* (Vermont) §5283(a)(5)(D); *DDA Act* (Washington) 70.245.120(3).
[47] The tick box compliance review has not been accepted uncritically. Hendin and Foley, and Keown in a separate publication, all fervid critics of Oregon's PAD framework, highlight that the review procedure adopted in Oregon — the prototype for PAD legislation throughout the US jurisdictions — is substandard and should not be used to review compliance with the legislative criteria: see Herbert Hendin and Kathleen Foley, 'The Oregon Report, Don't Ask, Don't Tell' (1999) 29(3) *Hastings Centre Report* 37; Hendin and Foley '(n 4); Kathleen Foley, 'The Oregon Experiment' in Kathleen Foley and Herbert Hendin, *The Case Against Assisted Suicide: For the Right of End-of-Life Care* (Johns Hopkins University Press, 2002); cf Katrina Hedberg et al, 'The Oregon Report: Neutrality at OHD?' (2000) 30(1) *Hastings Centre Report* 4; Keown (n 34).
[48] *ELOA* (California) 443.19(a); *ELOA* (Colorado) 25-48-111(2)(a); *DDA* (DC) § 7-661.16; *DDA* (Maine) §2140(17)(C); *MAID Act* (NJ) 26:16-13(4)(b); *DDA* (Oregon) 127.865 §3.11(2); *OCOCA* (Hawaii) §327L-14(c); *PCEL Act* (Vermont) § 5293(a); *DDA* (Washington) 70.245.150(2).

or biennially, detailing specific information about PAD,[49] often used as evidence of respect for procedure and transparency into PAD practice.

[49] *ELOA* (California) 443.19(b); *ELOA* (Colorado) 25-48-111(2)(a); DDA *(DC)* § 7-661.07(b); DDA *(Maine)* §2140(17)(D); *MAID Act* (NJ) 26:16-13(4)(c); *DDA* (Oregon) 127.865 §3.11(3); *OCOCA* (Hawaii) §327L-14(d); *PCEL Act* (Vermont) § 5293(b); *DDA* (Washington) 70.245.150(3).

Table 7 – Review Procedure by Jurisdiction – United States of America[1]

State	Review Body	Review Procedure
1. California	California Department of Public Health ('CDPH')	1. Retrospective; 2. AP must submit the patient's written request for PAD, AP's checklist and compliance form, and CP's compliance form within 30 days of issuing a prescription; 3. CDPH reviews compliance forms (above) to determine if legal criteria adhered to. **Medical Record Requirements:** 1. Initial determination and verification that the patient was acting voluntarily must be documented; 2. AP must note that they complied with the requirement to discuss with the patient privately that the request does not arise from coercion or undue influence.
2. Colorado	Department of Public Health and Environment ('CDPHE')	1. Retrospective; 2. AP must submit the Medication Reporting Form, the patient's written request for PAD, and CP's written report confirming diagnosis, prognosis and mental capacity within 30 days; 3. The CDPHE reviews a sample of medical records annually to ensure compliance. **Medical Record Requirements:** 1. AP's determination that the patient is making a voluntary request must be documented; 2. AP must note that they complied with the requirement to discuss with the patient privately that the request does not arise from coercion or undue influence.
3. District of Columbia	Department of Health ('DOH')	1. Retrospective; 2. AP must submit the AP's Compliance Form and CP's Compliance Form within 30 days of healthcare provider dispensing medication; 3. DOH will review compliance forms to ensure compliance with the law; 4. Office of the Chief Medical Examiner reviews each PAD death and may investigate the death.

[1] In this Table, Attending Physician and Consulting Physician have been abbreviated to AP and CP respectively.

State	Review Body	Review Procedure
		Medical Record Requirements: 1. AP's determination that the patient is acting voluntarily; 2. AP's notation that they complied with all legal requirements; 3. Patient's written request for PAD; 4. CP's verification that the patient was acting voluntarily.
4. Hawaii	Department of Health ('DOH')	1. Retrospective; 2. AP must submit the patient's Written Request Form for PAD, AP's Reporting Form, CP's Confirmation and Verification Form ,and Counseling Provider's Statement of Determination Form within 30 days of writing the prescription; 3. DOH annually reviews all information collected. **Medical Record Requirements:** 1. AP's determination that the patient was acting voluntarily; 2. CP's verification that the patient was acting voluntarily; 3. Patient's written request for PAD; 4. Statement by AP that all legal requirements have been met.
5. Maine	Department of Health and Human Services ('DHHS')	1. Retrospective; 2. DHHS conducts annual review of all PAD records; 3. AP must submit AP's Reporting Form and CP's Reporting Form within 30 days; 4. DHHS will collect information from AP to ensure compliance with the law, including compliance forms and further information reasonably necessary to determine compliance with the law if required. **Medical Record Requirements:** 1. AP's determination that the patient is acting voluntarily; 2. CP's verification that the patient was acting voluntarily; 3. Patient's written request for PAD; 4. AP must note that they complied with the requirement to discuss with the patient privately that the request does not arise from coercion or undue influence.

State	Review Body	Review Procedure
6. New Jersey	Department of Health (Office of the Chief State Medical Examiner) ('DOH')	1. Retrospective; 2. AP must submit the AP's Compliance Form, CP's Compliance form, and the AP's Follow up Form within 30 days of the patient's death; 3. Office of the Chief State Medical Examiner is charged with reviewing documentation and will contact AP for information and compliance forms/documentation if missing. **Medical Record Requirements:** 1. AP's determination that the patient is acting voluntarily; 2. CP's verification that the patient is acting voluntarily; 3. AP's notation that they complied with all legal requirements; 4. Written request for PAD.
7. Oregon	Oregon Health Authority ('OHA')	1. Retrospective; 2. AP must submit the AP's Compliance Form or the AP's Compliance Short Form accompanied by relevant excerpts of the patient's medical record, and the CP's Compliance Form within 7 days of writing a PAD prescription; 3. OHA reviews annually a sample of medical records; 4. OHA reviews compliance forms (above) to determine if legal criteria adhered to. **Medical Record Requirements:** 1. AP's determination that the patient is acting voluntarily; 2. CP's verification that the patient is acting voluntarily; 3. Patient's written request for PAD; 4. A note by the AP that all legal requirements have been met.
8. Vermont	Department of Health ('DOH')	1. Retrospective; 2. Prescribing physician must submit the Prescribing Physician's Reporting Form and CP's Reporting Form promptly after writing the prescription; 3. DOH reviews reporting forms (above) to ensure compliance with the law. **Medical Record Requirements:**

State	Review Body	Review Procedure
		1. Prescribing physician's determination that the patient is acting voluntarily; 2. CP's verification that the patient is acting voluntarily; 3. Patient's written request for PAD; 4. A note by the prescribing physician that all legal requirements have been met.
9. Washington	Department of Health ('DOH')	1. Retrospective; 2. DOH annually reviews all PAD records; 3. AP must submit the patient's Written Request Form for PAD, AP's Compliance Form, CP's Compliance Form, and Counseling Provider's Statement of Determination Form within 30 days of writing a prescription; 4. DOH reviews compliance forms (above) to determine if legal criteria adhered to. **Medical Record Requirements:** 1. AP's determination that the patient was acting voluntarily; 2. CP's verification that the patient was acting voluntarily; 3. Patient's written request for PAD; 4. A note by the AP that all legal requirements have been met.

Interpretation of 'voluntary' and 'free from undue influence' in the US jurisdictions

[9.60] The requirement to publish reports is a shared feature of PAD legislation amongst the US jurisdictions. In 1999, the Oregon Health Division reported that the impetus behind publishing annual reports helped to 'evaluate concerns that physician-assisted suicide might be forced onto the poor, uneducated or uninsured patients; or that it might be disproportionately sought by patients with inadequate end-of-life care'.[1] Consequently, the reports, not only in Oregon but throughout the relevant US jurisdictions, largely limit their analysis to a statistical overview enumerating data concerning diagnosis, level of education attained, and level/type of health insurance cover. Therefore, it is not surprising that there is no information released by the review bodies discussing undue influence. The legislative requirement operational in each state requires the review authority to produce a statistical summary of the data collected in compliance forms.[2]

The reports do not provide insight into the grey areas of PAD. For instance, under the *ELOA* (California), the Department of Health must publish an annual report on its Intranet Web Site detailing:[3]

- the number of PAD prescriptions authorised in the review period;[4]
- the number of people who died who had a PAD prescription authorised;[5]

[1] Department of Human Services, Oregon Health Division: Centre for Disease Prevention and Epidemiology, 'Oregon's Death with Dignity Act: The Second Years' Experience' *Oregon Health Authority* (pdf, 23 February 2000) 5 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>.
[2] See *ELOA* (California) 443.19(b); *ELOA* (Colorado) 25-48-111(2)(a); *DDA* (DC) § 7-661.07(b); *DDA* (Maine) §2140(17)(D); *MAID Act* (NJ) 26:16-13(4)(c); *DDA* (Oregon) 127.865 §3.11(3); *OCOCA* (Hawaii) §327L-14(d); *PCEL Act* (Vermont) § 5293(b); *DDA* (Washington) 70.245.150(3).
[3] *ELOA* (California) 443.19(b).
[4] Ibid 443.19(b)(1).
[5] Ibid 443.19(b)(2).

- the cumulative total of PAD prescriptions authorised since the *ELOA* (California) came into force, including the cumulative total of persons who died by ingesting PAD medication and whether they were enrolled in hospice or palliative care at the time of their death;[6]
- the ratio of PAD deaths per 10,000 deaths in California;[7]
- the number of physicians who authorised PAD prescriptions;[8]
- the demographic information of the people who died by ingesting PAD medications, including their:
    - age at death;
    - level of education attained;
    - race;
    - gender;
    - type of medical insurance, if any; and
    - underlying illness.[9]

This represents a limited scope of information which is a combination of demographical, straightforward statistics and other easily quantifiable data. There is an absence of interpretation or consideration of the quality of the process. Furthermore, the reports do

[6] Ibid 443.19(b)(3).
[7] Ibid 443.19(b)(4).
[8] Ibid 443.19(b)(5).
[9] Ibid 443.19(b)(6)(A)–(F). Centre for Health Statistics and Informatics, 'California End of Life Option Act 2016 Data Report' *California Department of Health* (pdf, 19 January 2021) <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx> ('ELOA Report California 2016'); Centre for Health Statistics and Informatics, 'California End of Life Option Act 2017 Data Report' *California Department of Health* (pdf, 19 January 2021) <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx> ('ELOA Report California 2017'); Centre for Health Statistics and Informatics, 'California End of Life Option Act 2018 Data Report' *California Department of Health* (pdf, 19 January 2021) <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx> ('ELOA Report California 2018'); Centre for Health Statistics and Informatics, 'California End of Life Option Act 2019 Data Report' *California Department of Health* (pdf, 19 January 2021) <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx>; <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData> ('ELOA Report California 2019').

not report adverse information. Instances of non-compliance with the legislative requirements are not disclosed in the US jurisdictions — barring Oregon — which has the effect of painting a skewed picture of PAD. It is uncertain why the respective state legislatures have chosen to limit the information provided in the statistical reports to only favourable datum as much can be learnt from the entire experience of PAD in the US jurisdictions. Adverse information can be utilised to identify any flaws in the system which could benefit patients and physicians alike.

The *Death with Dignity Act* (Washington) ('*DDA* (Washington)'),[10] which came into force in 2008, provides an illustrative example of the limitations of current reporting practices. The Washington State Department of Health commenced publishing annual activity reports in 2009 and, to date, 10 reports have been released.[11] The Washington annual reports refrain from providing any information concerning non-compliance with the law. Information on this point has not been made publicly available, and it remains to be seen if any PAD cases in Washington were ever subject to further investigation.[12] The

[10] RCW, 70-245-010—70.245.220.
[11] See also Washington State Department of Health, *Death with Dignity Data: Annual Reports* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>.
[12] See '2009 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>; '2010 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>; '2011 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>; '2012 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>; '2013 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>; '2014 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>; '2015 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>; '2016 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>'; '2017 Death with Dignity Act Report', *Washington State Department of Health* (Web Page) <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>; '2018 Death with Dignity Act Report', *Washington State Department of Health* (Web Page)

remaining jurisdictions, except Oregon, have adopted the same position.[13] Contrastingly, the annual activity reports published under the *DDA* (Oregon) provide information concerning cases of non-compliance with the law, albeit, as will be seen, this too, is limited. Since the *DDA* (Oregon) came into operation in 1997, 25 physicians have been referred to the Oregon Medical Board for alleged non-compliance with the law.[14] Instances of alleged

<https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>.

[13] DC Health, 'District of Columbia Death with Dignity Act 2017 Data Summary' *Government of the District of Columbia* (pdf) <https://search.usa.gov/search?query=death+with+dignity+act+summary&affiliate=dc_doh&emb=1>; DC Health, 'District of Columbia Death with Dignity Act Data Summary 2018 Data Summary', *Government of the District of Columbia* (pdf) <https://search.usa.gov/search?query=death+with+dignity+act+summary&affiliate=dc_doh&emb=1>; Centre for Health Statistics and Informatics, 'ELOA Report California End of Life Option Act 2016 Data Report'(n 9); ELOA Report California *Department of Health* (pdf, 19 January 2021) <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx>; ELOA Report California 2016 (n 9); ELOA Report California 2017 (n 9); ELOA Report California *Department of Health* (pdf, 19 January 2021) < https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx>; Centre for Health Statistics and Informatics, 'California End of Life Option Act 2018 Data Report' *California Department of Health* (pdf, 19 January 2021) < https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx>; ELOA Report California 2019 (n 9); Centre for Health and Environmental Data, 'Colorado End of Life Options Act – Year One: 2017 Data Summary', *Colorado Department of Public Health and Environment* (pdf, 2021) https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying#Annual>; Centre for Health and Environmental Data, 'Colorado End of Life Options Act – Year Two: 2018 Data Summary', *Colorado Department of Public Health and Environment* (pdf, 2021) https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying#Annual; Centre for Health and Environmental Data, 'Colorado End of Life Options Act – Year Three: 2019 Data Summary, with 2017-2019 trends and Totals', *Colorado Department of Public Health and Environment* (pdf, 2021) https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying#Annual; Department of Health, '2019 Our Care, Our Choice Annual Report', (Pdf, 1 July 2020) <https://health.hawaii.gov/opppd/files/2019/06/2019-Annual-OCOCA-Report-062819.pdf>; Department of Health, 'Report to the Thirteenth Legislature', *State of Hawaii* (pdf, 1 July 2020) <https://health.hawaii.gov/opppd/files/2020/06/2020-Annual-OCCOA-Report-1.pdf>; Office of the Chief State Medical Examiner, 'New Jersey: Medical Aid in Dying for the Terminally Ill Act', *Department of Health* (pdf, 31 July 2020) <https://nj.gov/health/advancedirective/maid/>; Vermont Department of Health, *Report Concerning Patient Choice at End of Life* (Online Report, 15 January 2018) https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf.

[14] Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2019 Data Summary', *Oregon Health Authority* (pdf, 6 March 2020) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('DDA Oregon Report 2019'); Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2018 Data Summary' *Oregon Health Authority* (pdf, 25 April 2019) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('DDA Oregon Report 2018'); Oregon Public Health Division, 'Oregon Death with Dignity Act 2010', *Oregon Health Authority* (pdf, January 2011) 2 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('DDA Oregon Report 2010'); Oregon Public Health Division, '2009 Summary of Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, March 2010) 2

non-compliance were documented in the reports up until 2010. Between 2011 and 2017, there were no cases of non-compliance reported;[15] in 2018 and 2019, one and two cases respectively were identified.[16] However, the reports do not disclose any information

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Oregon Public Health Division, 'Oregon's Death with Dignity Act 2006', *Oregon Health Authority* (pdf, March 2007) 2 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('DDA Oregon Report 2006'); Department of Human Services: Office of Disease Prevention and Epidemiology, 'Eighth Annual Report on Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, 9 March 2006) 13 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('DDA Oregon Report 2005'); Department of Human Services: Office of Disease Prevention and Epidemiology, 'Seventh Annual Report on Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, 10 March 2005) 14 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('DDA Oregon Report 2004'); Department of Human Services: Office of Disease Prevention and Epidemiology, 'Sixth Annual Report on Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, 10 March 2004) 13 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('DDA Oregon Report 2003'); Department of Human Services: Office of Disease Prevention and Epidemiology, 'Fourth Annual Report on Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, 6 February 2002) 4 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('DDA Oregon Report 2001'); Department of Human Services, Oregon Health Division: Centre for Disease Prevention and Epidemiology, 'Oregon's Death with Dignity Act: Three Years of Legalized Physician-Assisted Suicide', *Oregon Health Authority* (pdf, 22 February 2001) 10 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx> ('3 Year Review DDA Oregon'). See also John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2nd ed, 2018) 352–357.

[15] Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2011', *Oregon Health Authority* (pdf, March 2012) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2012', *Oregon Health Authority* (pdf, January 2013) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2013', *Oregon Health Authority* (pdf, January 20132014) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2014', *Oregon Health Authority* (pdf, February 2015) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2015', *Oregon Health Authority* (pdf, February 2016) 4 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2016', *Oregon Health Authority* (pdf, February 2017) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2017', *Oregon Health Authority* (pdf, February 2018) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>.

[16] DDA Oregon Report 2019 (n 14) 3; DDA Oregon Report 2018 (n 14) 3.

concerning specific details of the alleged contraventions or whether a full investigation of the patient's medical file was performed.[17] Of the annual reports where this information is available, failure to ensure that that the patient's written consent for PAD was properly witnessed was a frequently cited contravention.[18]

Under the *DDA* (Oregon), witnesses are called upon to certify that the person did not appear to be under undue influence in making their request. Therefore, there may have been reported breaches of the undue influence safeguards under the *DDA* (Oregon). Although this does not translate to a finding of undue influence, it is concerning nonetheless, as the consequence of failing to properly ensure that the person is acting free of undue influence can undermine the voluntariness of the request, the corollary of which

[17] Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2019 Data Summary', *Oregon Health Authority* (pdf, 6 March 2020) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Public Health Division: Center for Health Statistics, 'Oregon Death with Dignity Act: 2018 Data Summary', *Oregon Health Authority* (pdf, 25 April 2019) 3 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>.

[18] See Department of Human Services, Oregon Health Division: Centre for Disease Prevention and Epidemiology, 'Oregon's Death with Dignity Act: Three Years of Legalized Physician-Assisted Suicide', *Oregon Health Authority* (pdf, 22 February 2001) 10 < https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Department of Human Services: Office of Disease Prevention and Epidemiology, 'Fourth Annual Report on Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, 6 February 2002) 4 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Department of Human Services: Office of Disease Prevention and Epidemiology, 'Sixth Annual Report on Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, 10 March 2004) 13 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Department of Human Services: Office of Disease Prevention and Epidemiology, 'Seventh Annual Report on Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, 10 March 2005) 14 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Department of Human Services: Office of Disease Prevention and Epidemiology, 'Eighth Annual Report on Oregon's Death with Dignity Act', *Oregon Health Authority* (pdf, 9 March 2006) 13 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>; Oregon Public Health Division, 'Oregon Death with Dignity Act 2010', *Oregon Health Authority* (pdf, January 2011) 2 <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>. See 3 Year Review DDA Oregon (n 14) 10; DDA Oregon Report 2001 (n 14) 4; DDA Oregon Report 2003 (n 4) 13; DDA Oregon Report 2004 (n 14) 14; DDA Oregon Report 2005 (n 14) 13; DDA Oregon Report 2010 (n 14) 2.

is a non-voluntary death. No further discussion of the contraventions was provided and it was reported that no sanctions were initiated against physicians as they were found to have acted in 'good faith compliance'[19] — meaning that physicians are immune from sanction in cases where the legislative criteria are not met if they acted in 'good faith'.[20] As already indicated, cases of non-compliance are not publicly reported in the remaining US jurisdictions.

It is evident that the review bodies in the US jurisdictions have no role in interpreting the legal criteria, including undue influence. Their function is limited to checking compliance forms and collating statistical data to be published in the reports. Consequently, information on undue influence is not available and further discussion on undue influence in the US jurisdictions is not possible. While protection against undue influence is a core safeguard throughout the US jurisdictions, there is no information on it. South Australia should take note of this gap. This may be indicative of a larger issue, stemming from the inappropriateness of undue influence as a safeguard in this context.

Summary

[9.70] Legalisation of PAD is rapidly expanding throughout the United States of America. Over the past five years, there has been a notable rise in the number of jurisdictions permitting PAD and, undoubtedly, this number will continue to grow.[21] Upon review of PAD legislation across the relevant US jurisdictions, it is apparent that protection from

[19] The Oregon Medical Board was contacted directly to confirm whether any physicians had been sanctioned for non-compliance with the law: see Email from Michaela Estelle Okninski to Oregon Medical Board, 30 August 2017; Email from Oregon Medical Board to Michaela Estelle Okninski, 31 August 2017.
[20] Ibid.
[21] New Mexico, USA is exemplary of this trend. The *End of Life Options Act* was signed by the Governor of New Mexico on 8 April 2021: see The State of New Mexico, 'Elizabeth Whitefield End of Life Options Act' *New Mexico Legislature* (Web Page, 2021) <https://nmlegis.gov/Legislation/Legislation?chamber=H&legType=B&legNo=47&year=21>.

undue influence is a core safeguard that forms part of a broader framework of protections of voluntary decision-making. It is evident that there are striking similarities between the US jurisdictions and the historical South Australian bills with respect to protection against undue influence. The requirement to have witnesses consider questions of undue influence is near identical, as they must declare that they believe the person is not acting under undue influence. Similarly, there is no requirement for witnesses to have personally known the individual making the request, nor have specialist knowledge on undue influence. When coupled with lack of definitional guidance on undue influence, the veracity of the statutory protections against undue influence are seriously called into question.

The requirement for witnesses to examine for undue influence first arose in Oregon — the first jurisdiction to enact PAD legislation — and has been followed by all US jurisdictions since. However, California, Colorado and Maine have accentuated the undue influence provisions by obliging the attending physician to actively assess for elements of undue influence in a request for PAD, which more closely aligns with the proposed position in South Australia. However, despite the importance placed on safeguarding a voluntary request in the US jurisdictions, undue influence has never been defined. In fact, upon review of the literature on this point, there is minimal engagement with this issue, although some commentators have addressed this in passing, opining that the safeguards, in general, are 'largely illusory'.[22] Whilst the law boasts that review of all reported cases of PAD is undertaken, the type of review conducted is limited to examination of 'tick box' compliance forms, where the physician is required to check a box indicating that they complied with all the legislative requirements. Research indicates that no independent verification of the physician's contemporaneous notes in the patient's medical file is

[22] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (Cambridge University Press, 2nd ed, 2018) 356—57.

undertaken and the reports published in each jurisdiction are limited to a statistical overview of the data, with no adverse advents reported. Therefore, it is difficult to conclude whether the undue influence protections operational in the US jurisdictions provide meaningful protection of a voluntary decision. Although the legislative framework appears to place increased emphasis of safeguarding a voluntary decision, it remains to be seen how well such protections are working.

Introduction

[10.10] Voluntary assisted dying, known by the acronym MAiD (medical assistance in dying),[1] was decriminalised in Canada on 17 June 2016 when Bill C-14 — An *Act to Amend the Criminal Code and to make Related Amendments to Other Acts (Medical Assistance in Dying) Act* 2016 ('*MAID Act*')[2] came into force.[3] The *MAID Act* inserted amendments into the *Criminal Code,*[4] providing medical practitioners and nurse practitioners ('MP/NP' or 'Practitioners') with immunity from prosecution if they provide MAiD in accordance with the legislative requirements.[5] Prior to the enactment of the *MAID Act*, the province of Quebec had already taken steps to decriminalise MAID by enacting *An Act respecting End-of-Life Care* ('*ELC Act*'),[6] which came into force on 10 December 2015.[7]

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[1] There is a slight difference concerning the definition of MAID under the federal law and Quebec's provincial law. Under Canada's *Criminal Code,* R.S.C., (1985), c. C-46, ss. 241.1-241.4; *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)* 2016 ('*MAID Act*'), MAID means Medical Assistance in Dying. Under Quebec's *An Act respecting End-of-Life Care,* SQ 2014CQLR, c. 2S-32.0001 2014 ('*ELC Act*'), MAID is defined as Medical Aid in Dying. The acronym MAiD is still adopted in both legislations. For the purpose of this discussion, MAiD will be used when discussing the law in both jurisdictions. See also Chapter 1 for further discussion.

[2] *Criminal Code,* R.S.C., (1985), c. C-46, ss. 241.1-241.4.

[3] The *MAID Act* was the legislative response to the Supreme Court of Canada's declaration that the blanket prohibition of physician assisted dying was unconstitutional see *Carter v Canada (A-G)* [2015] 1 S.C.R. 331 ('*Carter*'). Analysis of the Court's decision and legal challenges that have occurred since the *Carter* decision is beyond the scope of this discussion.

[4] R.S.C., (1985), c. C-46, ss. 241.1-241.4.

[5] Although the *MAID Act* permits nurse practitioners to authorise requests for MAiD, this discussion will only focus on the obligations placed on medical practitioners. For further discussion on nurse practitioners and MAID: see, eg, Rosanne Beuthin, Anne Bruce and Margaret Scaia, 'Medical Assistance in Dying (MAiD): Canadian Nurses' Experiences' (2018) 53(4) 511; Barbara Pesut et al, 'Constructing Good Nursing Practice for Medical Assistance in Dying in Canada: An Interpretive Descriptive Study' (2020) 7 *Global Qualitative Nursing Research* 511; Michael Villeneuve, 'Medical Assistance in Dying: A Review of Canadian Regulatory Documents' (2020) 21(2) *Policy, Politics and Nursing Practice* 56.

[6] CQLR, c. S-32.0001, *ELC Act* s. 26-32 ('*ELD Act*').

[7] Legislative reform in Quebec was not in response to the Court's ruling in *Carter.* In fact, the *ELC Act* had already received assent prior to the court handing down its decision in *Carter* and the law was set to come into force on 15 December 2015. In *Truchon & Gladu v Attorney-General (Canada) & Attorney-General (Quebec)* [2019] QCCS 3792 — a recent legal challenge to the federal and provincial MAID legislation — Baudouin J commented at paragraph [120] on the legislative history of Quebec's *ELC Act*, stating that '[t]he Quebec statute is not the provincial legislature's reaction to a court judgment, but rather a social response to the Quebec medical community's initiative that sought a paradigm shift toward a holistic approach to the issue of appropriate end-of-life care'. For discussion on the path to legislative reform in Quebec, see

The subsequent enactment of the Federal Government's *MAID Act* did not invalidate Quebec's provincial law and both statutes operate concurrently in Quebec, although there are slight differences between the laws. One consistent feature, however, is that the Practitioner must ensure that the person's request was voluntarily made and was free from external pressure. For clarity of discussion, both statutes will be considered separately.

Canada: 'Voluntary and not the result of external pressure' — pivotal requirements of a valid request under the *MAID Act*

[10.20] Under the *MAID Act*, ensuring that the person's request is voluntary and not the result of external pressure operates as both a key eligibility requirement and substantive safeguard. Ensuring that voluntariness was well safeguarded was a key recommendation of the Special Joint Committee on Physician-Assisted Dying (the 'Committee'), established to make recommendations on a federal framework for MAiD.[8]

A central concern raised by stakeholders before the Committee was the impact legalisation of MAiD would have on vulnerable individuals in society, highlighting that such legislation may lead to abuse through individuals being pressured to request MAiD to prematurely end their life.[9] For example, Jennifer Gibson, Co-Chair of the Provincial-Territorial Expert Advisory Group — convened prior to the establishment of the

Select Committee on Dying with Dignity, National Assembly Quebec, *Dignity with Dying Report* (Report, March 2012) ('*Dignity with Dying Report*'); College des Medecins du Quebec, 'Physicians, Appropriate Care and the Debate on Euthanasia: A Reflection', *Publications and Regulations* (pdf, 16 October 2009) <http://www.cmq.org/publications/en.aspx?s=physicians+appropriate+care+and+the+debate+on+euth&p=1>.

[8] Special Joint Committee on Physician-Assisted Dying, Parliament of Canada, *Medical Assistance in Dying: A Patient Centred Approach* (1st Report, February 2016).

[9] Ibid 15–8.

Committee — [10]suggested that nearly all persons eligible to request MAiD were likely to be vulnerable in some way, but argued that 'instead of vulnerability being a barrier to access, the process should take these vulnerabilities into account through safeguards'.[11] The Committee agreed on this point, concluding that

> safeguards and oversight are the best way to ensure [that] voluntariness [is protected and] … the process of evaluating a request for MAID must include consideration by the relevant health care provider(s) of any factors affecting consent, such as pressure from others.[12]

The Committee's position on ensuring that voluntariness and freedom from external pressure were well protected were included as substantive safeguards in the *MAID Act* and must be assessed at defined points in time. It is important to note at the outset that, although the requirements of the *MAID Act* apply in all the provinces and territories, several provinces have implemented additional criteria to be satisfied when assessing the voluntary nature of the request for MAiD.[13] This is due to the jurisdictional overlap in responsibility between the federal and provincial governments in Canada, which, as a result, vested responsibility for the delivery of healthcare with the provinces. Whilst the following discussion is focussed on the requirements under the federal law, some discussion on the additional safeguards in force in the provinces will be provided, as these added provisions closely resemble the proposed response on this point in South Australia concerning protection against undue influence.[14]

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[10] Ibid 16.
[11] Ibid 16.
[12] Ibid 17.
[13] See College of Physicians and Surgeons of Nova Scotia, *Professional Standard Regarding Medical Assistance in Dying* (Web Page, 14 December 2018) <https://cpsns.ns.ca/standards-guidelines/medical-assistance-in-dying/> ('Professional Standard MAiD Nova Scotia'); *College of Physicians and Surgeons of* Manitoba *Standards of Practice of Medicine Regulation*, Man Reg 164/2018, sch M ('Professional Standard MAiD Manitoba'); see also James Silvius, Ameera Memon and Mubashir Arain, 'Medical Assistance in Dying: Alberta Approach and Policy Analysis' (2019) 38(3) *Canadian Journal on Ageing* 397; Michael Villeneuve, 'Medical Assistance in Dying: A Review of Canadian Regulatory Documents' (2020) 21(2) 56, 56.
[14] See Chapter 5 for discussion on undue influence provisions proposed in South Australia. For further discussion on the procedures in place in the individual provinces, see Professional Standard MAiD Nova Scotia; Professional Standard MAiD Manitoba, sch M; see also Silvius, Memon and Arain (n 13);

As shown in Table 6, to be eligible to access MAiD[15] the person must have made the request voluntarily and free from external pressure.[16] Furthermore, two independent MP/NP must be of the opinion that the request for MAiD was voluntarily made and not the result of external pressure.[17] Under the *MAID Act*, these terms have not been defined.[18] Whilst the fundamental legislative criteria are established under the *MAID Act*, as already highlighted, some provinces have gone further than the federal law. For instance, in Manitoba, Saskatchewan, Ontario, Nova Scotia and Newfoundland and Labrador the respective provincial Colleges of Physicians and Surgeons have endorsed professional standards of practice pertaining to MAiD, which operate in addition to the requirements under the *MAID Act*. In Manitoba and Saskatchewan, the standards require that each Practitioner who is assessing a person for MAiD must 'meet with the patient alone at least

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Government of Canada, 'Interim Reports on Medical Assistance in Dying in Canada', *Medical Assistance in Dying* (2 October 2020) <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a7> ('Interim Report MAiD Canada').

[15] Significant amendments to the *MAID Act* came into operation on 17 March 2021 after Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying) received Royal Assent. Detailed discussion of these amendments are beyond the scope of the *MAID Act*. Bill C-7 was introduced in response to the Superior Court of Quebec's decision in *Truchon and Gladu v Attorney General (Canada) and Attorney General (Quebec)* [2019] QCCS 3792. This discussion will consider the legislative provisions in force as of 30 June 2020. For further discussion on the proposed amendments, see Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying); Department of Justice, 'Proposed Changes to Canada's Medical Assistance in Dying Legislation', *Government of Canada* (Web Page, 10 September 2020) <https://www.justice.gc.ca/eng/csj-sjc/pl/ad-am/index.html>; 'Government of Canada Consults Canadians on Medical Assistance in Dying', *Government of Canada* (Web Page, 10 September 2020) <https://www.canada.ca/en/department-justice/news/2020/01/government-of-canada-consults-canadians-on-medical-assistance-in-dying.html>; Julia Nicol and Marlisa Tiedemann, 'Bill C-7: An Act to Amend the Criminal Code (Medical Assistance in Dying)' (Legislative Summary, Library of Parliament, Publication No.43-1-C7-E, 27 March 2020); Michaela Estelle Okninski, 'Why Death need not be 'Reasonably Foreseeable' — The Proposed Legislative Response to *Truchon and Gladu v Attorney General (Canada) and Attorney General (Quebec)* [2019] QCCS 3792 (2021) 18(1) *Journal of Bioethical Inquiry* 5; Michaela Estelle Okninski, 'Evolving Law: Further Developments Concerning MAID in Canada – Bill C-7 Receives Royal Assent' (2021) 18(3) *Journal of Bioethical Inquiry* (forthcoming).

[16] *MAID Act* s 241.2(1)(d).

[17] Ibid ss 241.2(3)(a), (e), (f), 241.2(6). The *MAID Act* is clear on what independence means and explicitly states that the MP/NP are independent if they are not in a mentor or supervisory role vis-à-vis each other: see s 241.2(6)(a). Moreover, independence is not only limited to the practitioners but independence from the person making the request is essential. Both the MP/NP either providing MAID or a confirming medical opinion cannot be beneficiaries under a will or have any financial interest or material benefit in the person's death: see s 241.2(6)(b). Finally, independence is satisfied if the practitioners 'know or believe that they are not connected to the other practitioner or to the person making the request in any other way that would affect their objectivity': see s 241.2(6)(c); see also Silvius, Memon and Arain (n 13) 400.

[18] See Table 6.

once to confirm that his/her decision to terminate his/her life is voluntary [and] made the decision freely and without coercion *or undue influence from family members, health care providers or others*'.[19] Furthermore, the Practitioner's findings on this point must be well documented in the patient's medical record.[20] The standard in place in Nova Scotia, Ontario and Newfoundland and Labrador is nearly identical, with the only point of difference being that there is no requirement to consult with the patient alone.[21]

The inclusion of the terms coercion and undue influence are more directive than the requirement under s 241.2(1)(d) of the *MAID Act*, which provides that the request must be made freely without external pressure. The heightened responsibility placed on medical practitioners in these selected provinces to ensure that a request for MAiD was voluntary is perhaps recognition of the need to provide broader, more explicit protection of a voluntary decision. To place a positive obligation on Practitioners to assess for undue influence bears a close resemblance to several past bills in South Australia. However, further information could not be located regarding whether these key protections have

[19] Professional Standard MAiD Manitoba sch M; 'MAiD (Medical Assistance in Dying), *College of Physicians and Surgeons of Saskatchewan* s 4(B)(3)(d) (Web Page, November 2018) <https://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Policies_page.aspx?Legislation_PoliciesCCO=1;> ('Professional Standard MAiD Saskatchewan'); 'Medical Assistance in Dying', *College of Physicians and Surgeons Ontario* s 7 (Web Page, 2020) <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Assistance-in-Dying>; ('Professional Standard MAiD Ontario').

[20] Professional Standard MAiD Manitoba sch M; Professional Standard MAiD Saskatchewan s 4(C).

[21] Professional Standard MAiD Nova Scotia 5.3.3, 6.4.2, 6.5.1, 8.1; Professional Standard MAiD Ontario s ;7 'Standard of Practice: Medical Assistance in Dying', *The College of Physicians and Surgeons of NewFoundland and Labrador*, cl 8.1(c) (Web Page) <https://www.cpsnl.ca/WEB/CPSNL/Standards_of_Practise/Policies__Guidelines__Advisories/CPSNL/Policies/Policies__Guidelines_and_Advisories.aspx?hkey=392e3ee4-8d3e-49d4-920b-369d54862c60>. A similar approach requirement is also in place in Prince Edward Island, see 'Policy on Medical Assistance in Dying', *The College of Physicians and Surgeons of Prince Edward Island*, 7 (Web Page, November 2019) <https://cpspei.ca/publications/policies/>; Standards of Practice for MAiD operational in the Northwest Territories and Yukon are silent on screening for undue influence see 'Medical Assistance in Dying: Interim Guidelines for the Northwest Territories' *Government of Northwest Territories* cl 1 (pdf, 17 March 2021) <https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/maid-interim-guidelines.pdf>; 'Medical Assistance in Dying', *Yukon Medical Council* (Web Page, 21 May 2021) < http://www.yukonmedicalcouncil.ca/standards.html>. Practice guidelines for MAiD could not be located for Quebec and Nunavut.

been defined. Thus, in the absence of information indicating the contrary, this is likely to undermine the efficacy of this increased framework of protections. It is apparent that the professional standards of medical practice in force in these provinces place a heightened obligation on Practitioners to safeguard a voluntary decision, yet the utility of this position is dubious if Practitioners are oblivious to what undue influence is.[22] In addition to this requirement, the *MAID Act* also has strict obligations with respect to the form of the request and signing procedures.[23]

A request for MAiD must be made in writing and witnessed by one independent witnesses.[24] The requirement that the request be in writing and signed are not uncommon; indeed, it is a standard requirement in most jurisdictions. However, under the *MAID Act*, there is no obligation on the witnesses to certify, declare or confirm whether the request appeared to be voluntarily made. Furthermore, as, MAiD in Canada operates as a defence for Practitioners against the offences of culpable homicide and aiding suicide,[25] harsh penalties apply for practitioners who fail to adhere to the statutory requirements.

Practitioners who knowingly fail to comply with ss 241.2(3)(a)–(h) — the safeguards — may be liable for a term of imprisonment if convicted.[26] However, given the severity of the custodial sentence, the prosecution must establish that the Practitioner 'knowingly' failed to comply,[27] thus enforcing a high bar to establish the *mens rea* of the offence. In terms of failing to comply with the standards of practice in force in selected provinces, the

[22] This issue will be explored in Part 3, where the use of undue influence in this context is critiqued.
[23] See *MAID Act* ss 241.2(3)(b)(i), (ii), (c), 241.2(4), 241.2(5)(a)-(d).
[24] Ibid s 241.2(3)(c).
[25] *Criminal Code*, R.S.C. (1985) c. C-46 ss 227, 241(1).
[26] If the Practitioner is convicted on indictment, the maximum penalty is five years imprisonment. If the Practitioner is convicted on summary then the maximum penalty is 18 months imprisonment: see *MAID Act* ss 241.3(a), (b).
[27] *MAID Act* s 241.3.

respective colleges will apply the standards, together with the relevant law, to determine whether the practice or conduct of the Practitioner was acceptable. To ascertain whether the Practitioner complied with the legislative criteria, compliance review is performed retrospectively by the relevant review authority.

Compliance review under the *Regulations for the Monitoring of Medical Assistance in Dying 2018*

[10.30] On 1 November 2018, the *Regulations for the Monitoring of Medical Assistance in Dying*[28] ('*MAID Regulations*') came into force, which established a federal, pan-Canadian monitoring and reporting system for MAiD.[29] However, instead of creating a unitary federal review body to determine compliance with the law, the regulations designate selected provinces as the responsible reporting authority,[30] with compliance determined at a provincial level.[31] For instance, in Ontario, the coroner is the responsible reporting

[28] SOR/2018-166 ('*MAID Regulations*').
[29] Prior to the federal monitoring system being implemented, the individual provinces and territories were responsible for monitoring and reporting on MAID. The procedures in place in each separate jurisdiction will not be considered here. For further discussion, see Government of Canada, 'Interim Reports on Medical Assistance in Dying in Canada', *Medical Assistance in Dying* (2 October 2020) <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#a7>; Report MAID Canada.
[30] See *MAID Regulations* ss 2(2)(a)–(f); *MAID Reporting for Alberta Practitioners Step by Step Guide*, Alberta Health Services (Web Page, 2020) <https://www.albertahealthservices.ca/info/Page16124.aspx> ('MAiD Reporting Alberta'). The provinces that have established a designated review body are British Columbia, Alberta, Saskatchewan, Nunavut, Northwest Territories, Quebec and Ontario: see Health Canada, *Medical Assistance in Dying in Canada 2019* (First Annual Report, July 2020) 13 ('2019 Report MAID Canada'). Comprehensive review of the additional procedures established in the provinces is beyond the scope of this discussion. For further information, see 'Guidance for Reporting on Medical Assistance in Dying', *Government of Canada* (Web Page, 29 September 2020) <https://www.canada.ca/en/health-canada/services/medical-assistance-dying/guidance-reporting-summary/document.html#7.0>; see also 'Fourth Interim Report on Medical Assistance in Dying', Government of Canada, 11 (Web Page, 25 April 2019) 11 <https://www.canada.ca/en/health-canada/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019.html>; see also Silvius, Memon and Arain (n 13) 399, 403–4; Mena Gewarges et al, 'Medical Assistance in Dying: A Point of Care Educational Framework for Attending Physicians' (2020) 32(2) *Teaching and Learning in Medicine* 231, 231; *An Act to Amend Various Acts with Respect to Medical Assistance in Dying*, RSO 2017, c 7.
[31] Health Canada, 'Medical Assistance in Dying (MAID) Federal Monitoring Regulations' 13 (Technical Briefing, 17 October 2018) <https://camapcanada.ca/wp-content/uploads/2019/02/briefing_EN.pdf>. In this technical briefing, Health Canada explicitly remarked that oversight and compliance review is separate from monitoring as provided under the *MAID Regulations*, and oversight is the responsibility of the provinces and territories.

authority and must be notified of deaths due to MAiD and determines whether or not to initiate an investigation concerning the provision of MAiD.[32] In Alberta, the Alberta Health Care Coordinator Service is the designated body to receive reports for MAiD, which it then forwards to the MAID Regulatory Review Committee and the Office of the Chief Medical Examiner for examination.[33] In the Northwest Territories, the Review Committee, established by the Government of the Northwest Territories, performs this function.[34]

Under the *MAID Regulations*, review of the legislative criteria is performed retrospectively. However, instead of limiting reporting requirements to cases where MAiD was administered, the *MAID Regulations* require Practitioners to, in certain circumstances, report to the relevant review body cases where the person was deemed ineligible for MAiD by failing to meet one or more of the eligibility criteria.[35] The impetus behind this position was that information pertaining to refused requests was important to ensure that a holistic picture of MAiD was presented, not just one limited to successful requests, which serves as an interesting contrast to the position adopted in the US jurisdictions where adverse information is largely kept silent, thus only providing a peripheral image of PAD.[36]

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[32] *An Act to Amend Various Acts with Respect to Medical Assistance in Dying*, RSO 2017, c 7, ss 1, 2.
[33] See MA;D Reporting Alberta; 'Standard of Practice: Medical Assistance in Dying', *College of Surgeons and Physicians of Alberta*, cl 6 (Web Page, June 2016) <http://www.cpsa.ca/standardspractice/medical-assistance-dying/>; see also Minister of Health (A), *Medical Assistance in Dying Regulatory Review Committee* (M.O. 38/2016, 7 June 2016).
[34] 'Medical Assistance in Dying: Interim Guidelines for the Northwest Territories, *Government of the Northwest Territories* (Guideline, 1 November 2018) s 22; see also 'New Federal Reporting Details', *Canadian Association of MAiD Assessors and Providers* (Web Page) <https://camapcanada.ca/federalreporting/>.
[35] *MAID Regulations* s 6(1). In cases where the person was deemed ineligible, the practitioner must provide documentation indicating which eligibility criteria were not met: see *MAID Regulations* sch 3(2)(a)-(i); see also Data and Stats: Medical Assistance in Dying, Alberta Health Services (Webpage, 2020) <https://www.albertahealthservices.ca/info/Page14930.aspx>.
[36] See Chapter 9.

In the First Annual Report on Medical Assistance in Dying in Canada ('First Annual Report')[37] the Health Minister — the Honourable Patty Hajdu — explicated that the need for such a robust system of reporting was broader than the provision of statistical data on the implementation of MAiD across Canada, and was designed to 'contribute to an evidence base important to future discussions on MAiD',[38] and the collection of data concerning refused requests was important to this dialogue. The reporting requirements for cases where MAiD has been administered are more robust when compared to situations where MAiD was refused.

In cases where the patient has elected to self-administer the MAID substance, the Practitioner must provide all relevant documentation to the applicable review board no later than 120 days after prescribing or providing the substance.[39] However, in cases where the Practitioner directly administers the MAiD substance, this is reduced to 30 days.[40] In both circumstances though, the nature of the report remains the same.[41] Important to this discussion is the requirement that the Practitioner document that the request for MAID was voluntary and not the result of external pressure, with the *MAID Regulations* stipulating that the Practitioner must provide reasons why the practitioner formed this opinion.[42] In the provinces where additional standards of medical practice have been introduced to supplement the legislative requirements under the *MAID Act*, Practitioners must also specifically document how they determined that the patient was not being coerced or unduly influenced to make the request.[43] Furthermore, the *MAID Regulations* require the Minister for Health to publish an annual report detailing the data

[37] 2019 Report MAID Canada.
[38] Ibid 7.
[39] *MAID Regulations* s 7(1).
[40] Ibid s 8(1)
[41] Ibid sch 1(1)(a), (c), (2)(a), (c), (d), (f).
[42] Ibid sch 3(2)(d).
[43] See, eg, Professional Standard MAID Saskatchewan ss 4(B)(3)(d), 4(C).

collected under the *MAID Regulations*, which also includes statistical information concerning refused requests,[44] therefore, demonstrating a commitment to a transparent discussion of MAiD in Canada.

The First Annual Report on MAiD provided some insight into the assessment of the voluntariness of the request. Practitioners explained that their means of assessing whether or not a request was voluntary went beyond discussions with the patient and extended to consultation with family and friends, reviewing medical records, consulting with other health professionals, and considering the long-standing relationship with the patient before reaching this conclusion.[45] This suggests that Practitioners apply a broad lens when ascertaining the voluntariness of a request, examining a wide variety of resources available to them to reach a determination on this point. As previously indicated, information pertaining to refused MAiD requests must also be collected. In 2019, 7.8% of requests for MAiD were refused and 1.6% of these refusals were on the basis that the Practitioner was not satisfied that the request was voluntary.[46] However, the annual reports are largely limited to statistical information, therefore, specific account of the reasons underlying why the Practitioner concluded that voluntariness was undermined was not provided. Thus, further discussion on this point is not possible.

Interpretation of 'voluntary and not the result of external pressure'

[10.40] As shown in Table 6, the key terms 'voluntary' and 'not the result of external pressure' have not been defined under either the *MAID Act* or the *MAID Regulations*.[47]

[44] *MAID Regulations* ss 13(1), 13(2)(a)-(i), 13(3).
[45] 2019 Report MAID Canada, 33.
[46] Ibid 38.
[47] See Table 6.

Furthermore, as considered above in **[10.30]**, the First Annual Report largely limits the information provided to a statistical overview.[48] Consequently, it is not possible to engage in further discussion on this point due the limited amount of available information. Factors that led to the conclusion that the request was not voluntary and free from external pressure would undoubtedly be beneficial for this discussion as it would provide important context to the parameters of these core safeguards.[49] Whilst it is evident that there has been some attempt to engage meaningfully with the voluntariness criterion, the brevity of discussion on this element of the law, however, impedes the ability to examine this factor in any more depth, which is disappointing given the impetus placed on safeguarding a voluntary consent. This could be viewed as a reflection of the lack of attention attributed to the significance of this important protection, and represents a missed opportunity to impute necessary meaning into this vital safeguard.

Upon review of the *MAID Act*, it is evident that safeguarding a voluntary request and ensuring that it is not the result of external pressure is integral to the law, with voluntariness being assessed by two independent Practitioners. These Practitioners must demonstrate that they considered this safeguard by detailing how they examined this core criterion when reporting to the authority designated to reviewing requests for MAiD, with several of the provincial medical colleges implementing additional standards on this point. Although the *MAID Act* is operational throughout all the provinces and territories in Canada, the Province of Quebec has its own MAiD legislation.

Quebec, Canada: Made freely and not the result of external pressure — pivotal requirements of a valid request under the *End-of-Life Care Act*

[48] 2019 Report MAID Canada, 38.
[49] See also Andreas Laupacis, 'Canada's Federal Government Should Continue to Proceed with Caution on MAiD Policy' (2020) 192(8) *Canadian Medical Association Journal* 188.

[10.50] Quebec's *Act Respecting End of Life Care* ('*ELC Act*')[50] came into force on 15 December 2015, nearly one year prior to the *MAID Act*, thus making Quebec quite progressive on this issue, as it was the first Canadian province to permit MAiD in controlled circumstances.[51] An important factor behind this ideological shift in attitude in Quebec were changes in social values, marked by the decline of religious practice and the increased importance of individual autonomy.[52]

Prior to the enactment of the *ELC Act*, a Select Committee on Dying with Dignity (the 'Committee') was convened by the National Assembly of Quebec to look into issues concerning end-of-life care, especially whether the law should be expanded to include MAiD.[53] The Committee published its report in March 2012, recommending that the law be amended to permit MAiD as part of the continuum of end-of-life care.[54] Important to the Committee's recommendation were major changes in social values, medical practice and the law, to which the Committee remarked that 'personal autonomy, inviolability and integrity, along with pluralistic values, have become the cornerstones of society. In view of this, we believe a person can choose to conduct his life according to his own personal values and beliefs'.[55] However, recognising that any subsequent MAiD legislation may lead to abuse and misuse, the Committee stipulated that stringent safeguards should be

[50] CQLR, c S-32.0000 ('*ELC Act*').
[51] Quebec passed the *ELC Act* well before the SCC's decision in *Carter* and the subsequent implementation of the *MAID Act*. However, prior to the nation-wide law reform, MAID under the *ELC Act* amounted to first degree murder under the Canadian *Criminal Code*. In response to this, the Attorney-General of Quebec granted immunity from prosecution to Quebec physicians who provided MAID in accordance with the legal requirements, which is permitted as the 'provinces have constitutional jurisdiction to administer the criminal law': see Sean Murphy, 'Legalisation of Assisted Suicide and Euthanasia: Foundational Issues and Implications' (2017) 31(2) *Journal of Public Law* 333, 338–39.
[52] See Select Committee on Dying with Dignity, *Dying with Dignity*, National Assembly of Quebec (Report, March 2012, 48; see also Silvius, Memon and Arain (n 13), 398.
[53] Ibid.
[54] See Select Committee on Dying with Dignity, *Dying with Dignity*, National Assembly of Quebec (Report, March 2012, 82.
[55] Ibid 49.

included, with the view to ensure, inter alia, that the request was freely made, without any external pressure.[56]

Similar to the position under the *MAID Act*, access to MAiD in Quebec requires the applicant to satisfy several eligibility criteria.[57] However, unlike the position under the *MAID Act*, ensuring that the request was made freely and not the result of external pressure is not an eligibility requirement and instead operates solely as a statutory safeguard. Under the *ELC Act* physicians — not nurse practitioners — must be of the opinion that the request for MAiD was freely made and not the result of external pressure.[58] Medical confirmation concerning the free and voluntary nature of the request is not required, as the role of the second independent physician is limited to confirming the person meets the eligibility criteria.[59] In the absence of independent verification of the voluntary nature of the request for MAiD, it appears that the *ELC Act* offers less protection of a voluntary decision that the federal *MAID Act*, which requires two Practitioners to assess that the request was voluntary and not the result of external pressure.

The *ELC Act* itself is silent concerning the procedural requirements for making a valid request, however, it must be made in writing on the prescribed *Request for Medical Aid in Dying Form.*[60] The Minister of Health and Social Services has provided conditions that must be met for a written request for MAiD to be valid.[61] Of importance to this discussion

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[56] Ibid 81-2.
[57] See *ELC Act* ss 26(1)-(5).
[58] Ibid s 29(1)(a).
[59] Ibid s 29(3). The requirement that the second physician be independent is essential and *ELC Act* requires both physicians to be independent of each other and the person making the request. However, the requirements for independence are not as explicit as they are in the *MAID Act*: see *ELC Act* s 29.
[60] *Regulation Respecting the Procedure Followed by the Commission sue les Soins de fin de vie to Assess Compliance with the Criteria for the Administration of Medical Aid in Dying and the Information to be sent to the Commission for that Purpose*, O.C. 997-2015, s 5 ('*Compliance Regulations*'); see also End of Life Care, '*Medical Aid in Dying: Procedures*' Government of Quebec (12 March 2020) <https://www.quebec.ca/en/health/health-system-and-services/end-of-life-care/medical-aid-in-dying/procedure/> ('MAID Procedures Quebec').
[61] See *Compliance Regulations* s 3(2)(b). For an overview of the procedural requirements see MAID Procedures Quebec.

is the imperative that two independent witnesses must witness the person making the written request for MAiD. There is, however, no obligation on witnesses to certify the voluntary nature of the request, which is consistent with the position under the *MAID Act*. Assessing voluntariness is the sole obligation of the physician who administers MAiD.

Granted requests for MAiD are not irrevocable and the request can be withdrawn at the physician's discretion.[62] The grounds for withdrawing granted requests have not been stipulated or defined, thus conferring a broad discretionary power on the physician. This is likely to include circumstances where the physician has concerns regarding the voluntary nature of the request, although this has not been made explicit in the *ELC Act*. Furthermore, compliance review is an important feature of the *ELC Act* and is performed retrospectively by the *Commission sur les soins de fin de vie* (the 'Commission').[63]

Compliance review under the *End-of-Life Care Act*

[10.60] The Commission, established under the *ELC Act,* is comprised of a multi-disciplinary team of experts, including health and legal professionals and ethicists.[64] The Commission must be notified within 10 days of cases where MAiD has been administered.[65] Anonymity of both patient and physician is integral to the review process. It is, however, not absolute and can be revoked if the information provided on the report is incomplete or it is determined that the physician did not comply with the law.[66] To ensure anonymity, the form of the report consists of two separate sealed sections.

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[62] *ELC Act* s 32.
[63] Ibid s 38; see also *Compliance Regulations*.
[64] *ELC Act* ss 39(1), (2) and (4).
[65] Ibid s 46; *Compliance Regulations* s 1. Furthermore, the *ELC Act* requires physicians to notify the *College des Medecins du Quebec* of instances where MAiD was administered who also perform their own internal review to ensure that MAID was provided according to acceptable clinical standards: see *ELC Act* s 36
[66] *Compliance Regulations* ss 9, 13.

The first section, which is used to determine compliance with the legislative criteria, contains no identifying information of the physicians or the patient involved in MAiD.[67] Instead it contains basic demographic information of the patient and requires the physician to report in detail how they ensured that all the eligibility requirements and statutory safeguards were complied with.[68] Importantly, the physician is required to substantiate how they confirmed that the decision was freely made and not the result of external pressure. This is achieved by providing a description of the 'verifications made by the physician to make sure that the request is freely made and more specifically that it is not made a result of external pressure'.[69]

Failure to properly consider the voluntary nature of the request may result in sanctions against the physician, with cases of non-compliance being referred to the *College des medecins du Quebec* (the 'College') for review.[70] The regulations are silent on what occurs after the case has been referred to the College. However, it is evident that the finding of the Commission is only preliminary and the decision whether to take action against the physician is determined by the College. In addition to review compliance, the Commission must also provide an annual report on MAiD to the Minister of Health and Social Services.[71] To date, four annual activity reports have been tabled in Quebec's National Assembly.[72]

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[67] Ibid s 2.
[68] Ibid s 3.
[69] Ibid s 3(1)(g).
[70] If two-thirds of Committee members determine that the legislative criteria were not complied with, then the case must be referred to the *College des Medecins du Quebec* for further action. Furthermore, if MAID was provided at a centre operated by an institution, the Commission will also inform the relevant institution of its finding: see *ELC Act* s 47; *Compliance Regulations* s 14.
[71] *ELC Act* s 42.
[72] Commission sur les soins de fin de vie, *Rapport Annuel D'Activites: du 1st Avril 2018 au 31 Mars 2019,* Government of Quebec (Rapport Annuel D'Activites, 2019) (French Only); Commission sur les soins de fin de vie, *Rapport Annuel D'Activites: 1er Juillet 2017 – 31 Mars 2018,* Government of Quebec (Rapport Annuel D'Activites, 2018) (French Only); Commission sur les soins de fin de vie, *Rapport Annuel D'Activites: 1er Juillet 2016 – 30 Juin 2017,* Government of Quebec (Rapport Annuel D'Activites, 2017) (French Only);

The Commission publish their annual activity reports in French only.[73] A review of the scholarly literature on this point has not yielded any detailed information in English, therefore it is not possible to engage in detailed discussion on this point. However, according to *Toujours Vivant – Not Dead Yet* (a Project of the Council of Canadians with Disabilities),[74] the Commission's cumulative report on the implementation of MAiD covering the period from 10 December 2015 until 31 March 2018[75] indicates that in 62 cases during this period the physician did not comply with the legislative safeguards. However, this was not discussed in detail,[76] therefore, it is uncertain what specific criterion or criteria were not complied with.

Interpretation of acting freely and not the result of external pressure

[10.70] Due to the paucity of information in English concerning the provision of MAiD in Quebec, further discussion on this point is not possible.[77] Furthermore, there has been no judicial consideration on this specific criterion in Quebec. All that can be said is that safeguarding against external pressure is a substantive safeguard and the physician must be satisfied that the request was voluntary in order to comply with the statutory criteria.

Commission sur les soins de fin de vie, *Rapport Annuel D'Activites: 10 Decembre 2015 – 30 Juin 2016,* Government of Quebec (Rapport Annuel D'Activites, 2016) (French Only).

[73] Direct communication with the Commission sur les soins de fin de vie was initiated to confirm the absence of data in English: see Email from Michaela Estelle Okninski to Commission sur les soins de fin de vie, 12 July 2017; Email from Michaela Estelle Okninski to Commission sur les soins de fin de vie, 7 November 2017; Email from Michaela Estelle Okninski to Commission sur les soins de fin de vie, 11 October 2020. The author would like to thank the General Secretary of the Commission sue les soins de fin de vie for their assistance.

[74] 'About Toujours Vivant – Not Dead Yet', *TVNDY* (Web Page, 2018) <https://tvndy.ca/en/about-not-dead-yet/>.

[75] Commission sur les soins de fin de vie, *Rapport sue la Situation sue les soins de fin de vie au Quebec: 10 Decembre 2015 au 31 Mars 2018,* Government of Quebec (Rapport, 2019) (French Only).

[76] 'Report #3 From the Commission sur les soins de fin de vie: Our Summary of the latest Data from Quebec', *TVNDY* (Web Page, 14 December 2018) <https://tvndy.ca/en/2018/12/report-3-from-the-commission-des-soins-de-fin-de-vie/?>.

[77] The Committee provided an overview of their first annual activity report in English; however, this was brief and contained no information regarding how either voluntariness was determined or whether this criterion was complied with: see Commission sur les soins de fin de vie, 'Annual Activity Report: Highlights' (2016) *Legislative Assembly of Quebec.*

Compliance with this criterion is assessed retrospectively by the Commission and failure to properly assess this criterion may be referred to the College for review.

Summary

[10.80] It is evident that, under both the *MAID Act* and the *ELC Act*, ensuring that a request was voluntarily or freely made, without external pressure, are fundamental requirements of a valid request, although differences are evident. The philosophical underpinning of this position is twofold. First, it serves to safeguard autonomy — a core element of autonomous choice is that it must expressed freely. The second comes from a position of protection. A longstanding argument in the ongoing debate, which has been alluded to throughout this thesis, is that vulnerable persons will be at risk of abuse by being externally pressured to request MAiD. Thus, safeguarding against unacceptable pressures was a legislative response to protect against abuse. However, differences in the legislative response to this matter are evident.

In selected provinces in Canada, several medical and surgical colleges have implemented additional standards of practice for MAiD, requiring Practitioners to assess for undue influence in a request. Whilst this may, prima facie, appear to be an improvement on the existing position under the federal law, what remains to be seen is whether undue influence provides meaningful protection against external pressure for patients or simply expose the Practitioner to unacceptable risk by enforcing a test that is inherently complex. The similarities in these standards of professional practice and the position in South Australia cannot be overlooked, as both place a positive obligation on Practitioners to assess for undue influence, not only of third parties, but of themselves in the process. The implications of this position will be considered in detail in Part 3.

Voluntary and well considered: the first due care criterion under the *Review Procedures Act*

[11.10] In the Netherlands, voluntary euthanasia and assisted suicide ('VE/AS') are criminal offences under arts 293 and 294 of the *Penal Code*, unless the due care criteria stipulated in the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act (2002)* ('*Review Procedures Act'*) are adhered to.[1] To attract the immunity, the physician must hold, inter alia,[2] 'the conviction that the request by the patient was voluntary and well considered'.[3] In the Netherlands, the practice of VE/AS predates the enactment of the *Review Procedures Act*, and ensuring that a request was voluntary and not the result of external pressure was one of the foundational protective safeguards incorporated into the initial judicial and regulatory frameworks.[4] Whilst this thesis focuses on the statutory responses to protecting against external pressure, a cursory discussion on these seminal cases is warranted because they provide meaningful insight into the underlying rationale of recognition of the need to safeguard free and unfettered decisions. Importantly, these decisions are not viewed in isolation of the *Review Procedures Act*, as they provided the foundation for later developments, with the judicial principles enshrined in the legislative framework and can be characterised as important foundational reasoning.[5]

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[1] *Wet Toetsing Levenbeeindiging op Verzoek en Hulp Bij Zelfdoding — Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002 (Nth)* ss 2(1)(a)–(f) ('*Review Procedures Act'*). For reproduction of arts 294 and 294 of the *Penal Code* in English, see Guenter Lewy, *Assisted Death in Europe and America* (Oxford University Press, 2011) 168.
[2] For the six due care criteria, see *Review Procedures Act* arts 2(1)(a)–(f).
[3] *Review Procedures Act* art 2(1)(a).
[4] See Barney Sneiderman and Marja Verhoef, 'Patient Autonomy and the Defence of Medical Necessity: Five Dutch Euthanasia Cases' (1996) 36(2) *Alberta Law Review* 374, 386–87.
[5] See especially Regional Euthanasia Review Committee, *Euthanasia Code 2018* (April 2018) 9, 21–4, 42–4 < https://english.euthanasiecommissie.nl/the-committees/code-of-practice> ('*Euthanasia Code*').

Legal reform for VE/AS began in 1973 with a decision handed down by the District Court of Leeuwarden, the Netherlands. In this seminal case, Dr Geertruida Postma administered a lethal dose of morphine to her gravely ill mother, at her explicit request, with the intention of ending her life.[6] Dr Postma made full disclosure of her act and was subsequently arrested and charged under art 293 of the *Penal Code*. Dr Postma was convicted and placed on a one-year bond — a relatively lenient sentence. Despite the conviction, the Court expounded a series of conditions applicable for future analogous cases to serve as grounds to acquit physicians charged under s 293 of the *Penal Code.*[7] The Court did not explicitly remark that the request must be made voluntarily. They did, however, emphasise that the request must come from the patient directly, alluding to the potential impact third parties may have on a voluntary consent,[8] thus demonstrating recognition of the significance of voluntary decisions and paving the way for future protective measures that specifically identify the need for voluntary decisions as required under current law.

This case represented the crucial first step towards legalisation of VE/AS in the Netherlands. However, VE/AS was viewed with trepidation by the medical profession as its legal status was marred with uncertainty, and criminal prosecution for participating VE/AS remained a real risk.[9] This legal uncertainty was clarified — but not resolved — in 1984 by the Supreme Court of the Netherlands,[10] and the Dutch medical college, the KNMG, which marked a significant turning point for the development of VE/AS.

[6] *Postma*, District Court, Leeuwarden, 21 February 1973, N.J. 1973, No. 183.
[7] For further discussion, see especially Sneiderman and Verhoef (n 4) 385.
[8] Ibid.
[9] Ibid.
[10] *Schoonheim,* Supreme Court, 27 November 1984, N.J., 1985, No. 106 ('*Schoonheim*').

In 1984, the executive committee of the Dutch medical association, the KNMG (the 'College'), endorsed the practice VE/AS in an article titled 'Vision on Euthanasia'.[11] The article established some clear regulatory guidelines concerning the provision of VE/AS, explicating that physicians do not breach the code of medical ethics when administering VE/AS, either directly or indirectly, if the guidelines are adhered to. It was at this point in time that the College explicitly turned their mind to the vitiating effect external pressure would have on consent.

It was stipulated by the College that the decision to request VE/AS must be 'the exercise of … free will and not the decision of [the] family'.[12] On this point, the College further emphasised that the voluntariness of the request is of paramount importance and if the request is 'communicated in the presence of the family, the physician must confer privately with the patient'.[13] These guidelines became a fundamental consideration in one of the landmark cases on VE/AS — the *Schoonheim*[14] case which provided crucial clarity concerning the scope and operation of the defence of necessity as it applied to physicians who have performed VE/AS.

In *Schoonheim*, Dr Schoonheim — a family physician — was charged under art 293 for actively euthanising his 95-year-old patient, who was described as suffering intolerably and at the end-of-life.[15] Dr Schoonheim raised the defence of necessity under art 40 of the

[11] Central Committee of the Royal Dutch Medical Association, 'Vision on Euthanasia' (1984) 39 *Medisch Contact* 990, cited in Sneiderman and Verhoef (n 4), 386–87. Furthermore, the College was willing to endorse the practice of assisted suicide, which it had declined to do so in 1973 when the *Postma* decision was handed down: see Sneiderman and Verhoef (n 4) 386.
[12] Sneiderman and Verhoef (n 4) 386.
[13] Ibid 387.
[14] *Schoonheim;* see especially ibid 388-92.
[15] For discussion on the facts see Sneiderman and Verhoef (n 4) 388–89.

Penal Code.[16] The defence was successful at trial, however, was overturned on appeal.[17] Dr Schoonheim appealed to the Supreme Court, who rejected the reasoning of the Court of Appeal — that the necessity defence could not operate as a defence to mercy killing under art 293 — and remitted the matter back to the lower court with direction on the law. Pertinent to the Supreme Court's decision was that the Court of Appeal failed to give proper consideration to 'whether, according to responsible medical opinion, subject to the applicable norms of medical ethics, this was, as claimed by the defendant, a situation of necessity'.[18] It was ultimately this issue that the lower court had to consider.

In the Netherlands, the Supreme Court is not the final arbiter on findings of fact,[19] therefore when the case was remitted to the lower court for determination, the directions offered by the Supreme Court were whether a conflict of duties arose between the 'duty to abide by the law and his duty to help his patient who pleads for active intervention to end a life marked by unbearable and irremediable suffering'.[20] A further point for consideration was whether Dr Schoonheim was confronted with an emergency situation, taking into account the circumstances of his patient and the opinions of the medical profession on this point.[21]

At the retrial before the lower court, Dr Schoonheim received overwhelming support from the medical profession who were called to give expert evidence. This resulted in the prosecution eventually dismissing the charge on the basis that it was unlikely that they

[16] Ibid 390–92.
[17] For discussion on the Supreme Court's decision to overturn the Court of Appeal's findings, see John Griffiths, Alex Bood and Heleen Weyers, *Euthanasia and the Law in the Netherlands* (Amsterdam University Press, 1998) 62–3.
[18] Ibid 63.
[19] Ibid.
[20] Ibid 390.
[21] Ibid.

could secure a conviction. Of significance to this prosecutorial discretion was the fact that the prosecution consulted with the medical College (KNMG), seeking their advice concerning whether the circumstances of the case fell within the scope of accepted medical ethics and practice.[22] To this, the College responded that 'if the criteria of voluntariness, a well considered request and unbearable suffering have been met … euthanasia is in principle allowed,'[23] which were accepted facts in the dispute. Thus, the publication of guidelines by the College concerning administration of VE/AS, the Supreme Court's decision, and the subsequent withdrawal of the charges in *Schoonheim* established a solid foundation for the practice of VE/AS in the Netherlands. Although there were calls for parliamentary intervention on the growing issue of VE/AS, the response was quite slow and formal steps to legislatively regulate reporting procedures for VE/AS were not taken until 1994.[24]

The legislature refrained from enacting an independent piece of legislation to regulate and control the provision of VE/AS, and instead amended the existing *Law on the Disposal of Corpses* to include provisions specific to reporting cases of VE/AS.[25] This amendment introduced a new set of criteria, established by an Order in Council, for physicians to adhere to in reporting cases of VE/AS to the municipal coroner, effective 1 June 1994.[26] The Order in Council required physicians, amongst other things, to justify in a detailed report that the request for termination of life on request and assisted suicide was

[22] Ibid.
[23] Ibid.
[24] There are other seminal cases that occurred after *Schoonheim* which clarified the scope of VE/AS in the Netherlands that have not been considered here. For further discussion, see especially Sneiderman and Verhoef (n 4); Griffiths, Bood and Weyers (n 17) 321–51; see also Lewy (n 1).
[25] Law of 2 December 1993, *Staatsblad* 1993: 643. For full reproduction of the law in English, see Griffiths, Bood and Weyers (n 17) 308–13.
[26] See Griffiths, Bood and Weyers (n 17) 309–13.

'completely voluntary, explicit, well-considered and lasting'.[27] If these criteria had not been properly reported, then the likely consequence would be criminal investigation and/or liability for the unlawful termination of life. These criteria, were eventually included as substantive due care criteria in the *Review Procedures Act* that came into force 1 April 2002.

Under the *Review Procedures Act*, the voluntary nature of the request is the first due care criterion in the law, thus reinforcing the significance of voluntariness in a request for VE/AS evidenced by its preeminent position as the first due care criterion.[28] As further evidence of the paramountcy attributed to ensuring that a request was externally voluntary — free from external pressure or unacceptable influence — any breach of this provision is deemed a significant contravention of the law that may result in criminal prosecution.[29] Furthermore, voluntariness must be considered by two independent physicians.[30] Ensuring that a second independent physician has examined the patient and assessed that the request was (externally) voluntary is a vital safeguard to ensure protection of a voluntary decision.[31] It is, however, the responsibility of the first physician to ensure that all due care criteria were satisfied, as they are criminally liable under the *Review Procedures Act*, and not the independent physician.[32] Failure to refer to a second

[27] Ibid 311. The impetus behind attributing legal status to the reporting procedure was to ensure uniformity in the decision-making process; that is, uniformity in deciding whether criminal charges will be brought against the physician. As VE/AS was not legalised, all cases were treated as criminal cases and had to still be reported to the municipal public prosecutor, with the Minister of Justice being the ultimate arbiter on whether charges will be brought against a physician: see Lewy (n 1) 24. For discussion on the evaluation of cases of VE/AS by the public prosecutor, see Gerrit van der Wal et al, 'Evaluation of the Notification Procedure for Physician Assisted Death in the Netherlands' (1996) 335(22) *New England Journal of Medicine* 1706, 1708–09.
[28] *Review Procedures Act* arts 2(1)(a), 2(1)(e).
[29] See **[11.20]**, 186-189.
[30] *Review Procedures Act* arts 2(1)(a), 2(1)(e).
[31] 'External voluntariness' is the term used in the *Review Procedures Act* to denote the requirement that the person requesting VE/AS was not experiencing unacceptable pressure from an outside source. It bares close resemblance to undue influence, which has in the Australian case law on undue influence been considered a form of unacceptable external pressure. External voluntariness is considered below.
[32] *Review Procedures Act* art 2(1).

physician for consideration of the voluntary nature of the request will be deemed a case of non-compliance and may be subject to further investigation for potential disciplinary action or criminal liability.[33]

As shown in Table 6, no definition of 'voluntary and well considered' has been provided in the *Review Procedures Act*; however, the elements of this criterion have been discussed by the *Regionale Toetsingscommissies Euthanasie* (Regional Euthanasia Review Committee(s) (the 'Committee(s)')),[34] who advise that there are several important elements of this criterion. First,

> [t]he request for termination of life or assisted suicide must have been made by the patient himself. [Second] [i]t must be voluntary. There are two aspects to this. The request must be internally voluntary, i.e. the patient must have the mental capacity to determine his own wishes freely, and *externally voluntary, i.e. he must not have made his request under pressure or unacceptable influence from those around him*. [Third] [i]n order to make a well-considered request, the patient must be fully informed and have a clear understanding of his disease. The patient is considered decisionally competent if he is capable of making an internally voluntary, well-considered request.[35]

Therefore, it is evident that this criterion itself requires consideration of complex facts which is not explicitly obvious in the text of the *Review Procedures Act*. Due to the narrow focus of this thesis, only the second limb — externally voluntary — of the 'voluntary' criterion will be considered here. Whether the physician properly considered the voluntariness of the request is determined retrospectively by the Committee, who are vested with the function to review all reported cases of voluntary euthanasia and assisted suicide.

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[33] See especially Regional Euthanasia Review Committee, *Annual Report 2019* (March 2020) 91–3 <https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports> ('*Annual Report 2019*').
[34] The role of the regional review committee will be discussed in detail at **[11.20]**.
[35] Regional Euthanasia Review Committee, *Annual Report 2010* (2011) The Hague, 11 <https://www.euthanasiecommissie.nl/uitspraken/jaarverslagen/2010/nl-en-du-fr/nl-en-du-fr/jaarverslag-2010> ('*Annual Report 2010*') [own emphasis]; see also *Euthanasia Code.*

Review procedure under the *Review Procedures Act*

[11.20] Determination of whether the physician properly 'satisfied [themselves] that the request is voluntary' is decided *a posteriori*. Immediately following the patient's death, the medical practitioner who performed VE/AS must notify the municipal pathologist of the cause of death and submit a report demonstrating compliance with the due care criteria.[36] The municipal pathologist does not assess the report but forwards the documentation to the relevant Committee, where it is considered whether the physician determined that the request was, inter alia, externally voluntary.

There are five Committees throughout the Netherlands, each covering a defined jurisdiction,[37] who review all reported cases of VE/AS. Each Committee is comprised of physicians, lawyers, and ethicists.[38] This multi-disciplinary composition is mandatory because each discipline reviews reported cases through their own professional lens; thus, bringing essential insight and wide-ranging expertise when determining compliance with the different aspects of the due care criteria, which includes issues across the medical, legal and ethical spectrum. As a means to improve efficiency and timely review of reported cases as mandated in the *Review Procedures Act*,[39] the Committees divide reported cases into two categories: straightforward and non-straightforward. It is the responsibility of the Committee Secretary — a trained lawyer — to ascertain which

[36] *Burial and Cremation Act* (Nth) arts 7(2), 8(1).
[37] See *Annual Report 2019*.
[38] *Review Procedures Act*, art 3. In 2020, the Committee finalised consolidating the municipal branches of the Committee into one central institution. Prior to this, there were five separate Committees which covered a defined jurisdiction in the Netherlands. This merging was expected to enhance and improve the operation of the Committees: see Regional Euthanasia Review Committee, *Annual Report 2018* (March 2019) 7 <https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports> ('*Annual Report 2018*').
[39] *Review Procedures Act* art 9(1).

category the case will be delegated to and this question is dependent upon several factors.[40]

It is reported by the Committee that the majority of reported VE/AS cases are deemed straightforward and the procedure mandated in these cases is that they are sent to Committee members for consultation and review digitally, thus fast-tracking the review process.[41] The cases deemed non-straightforward must be reviewed at monthly Committee meetings. Several important factors define cases as either straightforward or non-straightforward, which include the quality of the physician's report or whether the case raises complex legal/medical issues or it cannot be clearly ascertained that the physician lawfully terminated life.[42]

The Committee is vested with quasi-judicial power to determine compliance with the statutory due care criteria.[43] Therefore, the Committee has discretionary power to interpret the due care criteria to determine whether, based on the evidence provided by the physician, the request was externally voluntary — that is, free from external pressure or unacceptable influence.[44] However, a caveat on this discretionary power is that when

[40] This new procedure for reviewing reported cases came into effect in April 2012. The impetus behind this review of procedure was due to the nearly annual increase in the number of reported cases of VE/AS in the Netherlands which was causing a significant backlog of cases to be reviewed by the Committee: see Regional Euthanasia Review Committee, *Annual Report 2012* (July 2013) 5–6 <https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports> ('*Annual Report 2012*'); Regional Euthanasia Review Committee, *Annual Report 2013* (September 2014) 7–11 <https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports ('*Annual Report 2013*').

[41] *Euthanasia Code*, 10–6; *Annual Report 2018*, 11.

[42] *Euthanasia Code*, 10–6; see also Michaela Estelle Okninski, 'A Comparative Analysis of Voluntariness Safeguards and Review Procedure Under Oregon and the Netherlands Physician Assisted Dying Laws' (2018) 41(1) *Dalhousie Law Journal* 121.

[43] See, eg, Jabob Koopman, 'Further Turns in the Conception and Regulation of Physician-Assisted Dying in the Netherlands' (2019) 132(9) *American Journal of Medicine* 1011.

[44] *Euthanasia Code* 10–6; *Annual Report 2018,* 6–9. The breadth of the Committee's power in interpreting the DDC has been subject to criticism: see Koopman (n 43); Johan Legemaate and Ineke Bolt, 'The Dutch Euthanasia Act: Recent Legal Developments' (2013) 20 *European Journal of Health Law* 451, 454.

reviewing cases the Committee must have regard to previous case law, the legislative history and context of the *Review Procedures Act*, as well as previous decisions of the Committee/s.[45]

In determining whether the physician ensured that the request was externally voluntary, the test applied by the Committees is one of reasonableness — that is, based on the evidence provided, was the physician able to reasonably conclude that the request was externally voluntary.[46] It therefore appears to be a relatively low threshold test that does not require examination of any objective criteria but is instead a question solely reserved for both the euthanising and independent physicians to be determined on a case-by-case basis.[47] Whilst the Committee's decision to determine compliance with the law is near final, in cases of non-compliance, their power is not absolute and the decision is only a provisional finding.[48]

The decision to commence disciplinary action or to prosecute a physician resides with the Health and Youth Care Inspectorate (the 'HC Inspectorate') and the Board of Procurators General (the 'BPG').[49] Prior to making any referral, the Committee will afford the physician the opportunity to adduce additional information to justify their action.[50] The roles of the

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[45] See Regional Euthanasia Review Committee, *Annual Report 2013* (September 2014) 4 < https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>.
[46] *Euthanasia Code,* 10–6; *Annual Report 2018*, 10–1
[47] Although, as will be discussed at **[11.30]**, the Committee have established some broad parameters concerning external voluntariness through the publication of selected decisions.
[48] Ibid. See also David Miller and Scott Kim, 'Euthanasia and Physician-Assisted Suicide not Meeting Due Care Criteria in the Netherlands: A Qualitative Review of Review Committee Judgments' (2017) 7(10) *British Medical Journal* 1.
[49] *Review Procedures Act* art 8(1). Decisions whether to prosecute physicians who violate the due care criteria are based upon the 'Instructions on prosecution decisions in the matter of termination of life on request and assisted suicide' (Aanwijxing vervolginsbeslissing levensbeeindiging op verzoek (euthanasie en hulp bij zelfdoding)). The prosecutorial guidelines are available in Dutch at <http://www.om.nl/vaste-onderdelen/zoekrn/@86299/aanwijzing-5/>; see also *Annual Report 2018*, 6.
[50] *Review Procedures Act* art 8(2); see also Regional Euthanasia Review Committee, *Annual Report 2016* (March 2017) 48–9 <https://english.euthanasiecommissie.nl/the-

HC Inspectorate and the BPG differ, and each body conducts its investigation through its own professional lens. For instance, the HC Inspectorate investigates whether the physician, in providing VE/AS, constitutes a risk to healthcare and will examine the physician's administration of VE/AS against guidelines of professional conduct and, if necessary, initiate proceedings against the physician before the Central Disciplinary Board.[51] The BPG, on the other hand, reviews whether any criminal charges can be brought against the physician for allegedly administering VE/AS contrary to the legal criteria — that is, they did fail to terminate life with due care.[52]

Furthermore, when conducting an investigation, the BPG divides the due care criteria into two categories — material and non-material standards — and whether the criminal proceedings are initiated generally depends on which aspect of the law was breached.[53] Failure to ascertain that the request for VE/AS was voluntary and well considered is viewed as a material due care standard, and is, therefore, a substantial breach of the law that is more likely to attract criminal investigation for non-compliance.[54] This strict position indicates that ensuring that the request was externally voluntary is considered a vital safeguard and failure to properly ascertain this may render the physician liable for prosecution. Given the significance attributed to external voluntariness under the *Review Procedures Act,* both as a statutory protection for patients and a potential criminal offence for physicians, it is surprising that the law itself and the literature released by the

committees/documents/publications/annual-reports/2002/annual-reports/annual-reports> ('*Annual Report 2016*').

[51] See especially District Court of the Hague, ECLI NL RBDHA 2019 10650, 11 September 2019, [3.1]–[3.3]; see also Royal Dutch Medical Association and Royal Dutch Pharmacists Association, '*Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide*' (2012) <https://www.knmg.nl/advies-richtlijnen/knmg-publicaties/publications-in-english.htm>; Eva Constance, Alida Asscher and Suzanne van de Vathorst, 'First Prosecution of a Dutch Doctor since the Euthanasia Act of 2002; What does the Verdict Mean?' (2020) 46 *Journal of Medical Ethics* 71, 72; see also Sean Riley, Anouk Overbeek and Agnes van der Heide, 'Physician Adherence to Clinical Guidelines in Euthanasia and Assisted Suicide in the Netherlands: A Qualitative Study' (2020) 37(2) *Family Practice* 269.

[52] *Annual Report 2018*, 6. For discussion on how each body conducts its review, see generally Constance, Asscher and van de Vathorst (n 51).

[53] *Annual Report 2018*, 7–8.

[54] Ibid; see Constance, Asscher and van de Vathorst (n 51).

Committees on external voluntariness has remained largely silent concerning what external voluntariness actually is. This is reminiscent of the position adopted in several South Australian VAD bills where a term of similar equivocality — undue influence — was relied on without explication.

Cases of non-compliance or cases that raise novel issues are generally detailed by the Committee in their annual activity report, which also includes statistical data regarding the provision of VE/AS. The annual activity reports contain explanatory information concerning how compliance with the due care criteria are assessed, which serves both an educative and informational function for physicians and the broader public.[55] Since the enactment of the *Review Procedures Act,* several cases have been referred to the HC Inspectorate and the BPG for further examination; however, professional disciplinary action and/or prosecution for noncompliance with the law are rare.[56] In 2018, one case was brought before both the medical disciplinary board and criminal court concerning administration of VE/AS to a patient with advanced dementia pursuant to an Advance Euthanasia Directive ('AED').[57]

AEDs are lawful under the *Review Procedures Act*.[58] This permits persons, usually diagnosed with a degenerative neurological disease such as Alzheimer's, to make an

[55] *Review Procedures Act* art 17.
[56] Miller, Dresser and Kim report that, between 2002, when the *Review Procedures Act* came into force, and 2016, 89 cases were referred to the BPG but only one case proceeded to prosecution: see David Miller, Rebecca Dresser and Scott Kim, 'Advance Euthanasia Directives: A Controversial Case and Its Ethical Implications' (2019) 45 *Journal of Medical Ethics* 84, 88; see also Sean Riley, Anouk Overbeek and Agnes van der Heide, 'Physician Adherence to Clinical Guidelines in Euthanasia and Assisted Suicide in the Netherlands: A Qualitative Study' (2020) 37(2) *Family Practice* 269; *Annual Report 2018*, 6. In the Committee's 2016 Annual Activity Report, it was reported that most cases of non-compliance concern failure to consult an independent physician and failure to administer VE/AS with due medical care: see *Annual Report 2016,* 47.
[57] For discussion on the facts of the case and subsequent investigations, see also Miller, Dresser and Kim (n 56); Constance, Asscher and van de Vathorst (n 51).
[58] *Review Procedures Act* art 2(2).

advance request for VE/AS which becomes operational at a defined point in the future when they are mentally incompetent.[59] These types of cases pose significant challenges for physicians as they have to ascertain whether the now incompetent patient made a historical voluntary and well considered request for VE/AS in an AED.[60] As discussions with the patient on this point are no longer possible, to ensure that this due care criterion has been met, the physician must examine the AED itself, consult with the patient and their medical records, consult with the patient's past and present medical team, and engage in discussions with the patient's loved ones to ascertain this point.[61] Thus, based upon their examination of this evidence, the physician must be able to form a reasonable conviction that the patient's request was externally voluntary when the AED was executed. To discharge this obligation it would need to be clearly documented that the patient was not being forced or experiencing improper pressure by an external party to draft the AED. If there is insufficient evidence to establish this conviction, then the VE/AS should not be administered as this element of due care cannot be satisfied. Whether a request for VE/AS made pursuant to an AED was voluntary and well considered was a primary matter for consideration before the Criminal Court of the Hague when the first physician was prosecuted for failing to terminate life with due care.

In this case, the alleged contraventions of the law were that the physician — Dr Marinou Arends — failed to properly consider that the request was voluntary and well considered and failed to terminate life with due care —[62] that is, the euthanasia was not

[59] See, eg, *Annual Report 2016* 54–58; J J M van Delden, 'The Unfeasibility of Requests for Euthanasia is Advance Directives' (2004) 30 *Journal of Medical Ethics* 447; C M P M Hertogh, 'The Role of Advance Euthanasia Directives as an aid in Communication and Shared Decision Making in Dementia' (2009) 35(2) *Journal of Medical Ethics* 100.
[60] Furthermore, the physician has to ensure that all the due care criteria in arts 2(1)(a)—(f) of the *Review Procedures Act* have been met.
[61] District Court of The Hague, ECLI NL RBDHA 2019 10650, 11 September 2019, [5.3.1].
[62] *Review Procedures Act* arts 2(a)–(f).

performed in accordance with standards of professional practice which concerns the clinical aspects of the administration of euthanasia.[63] This is the first instance where a court has ever been called upon to interpret the provisions of the *Review Procedures Act*, especially focussing on the voluntary and well considered criterion.[64] However, detailed analysis of this case is not warranted as the external voluntariness of the request was not in issue. The primary issue for consideration before the Court, which formed the basis of the prosecution case, was whether a physician is obliged, immediately prior to administering VE/AS pursuant to an AED, 'to verify the whish [sic] to live or to die with an incapacitated or profoundly demented patient'.[65] The prosecution case centred on the fact that because the (now mentally incompetent) patient rejected administration of VE/AS, inconsistent with her AED, the failure to obtain a contemporaneous wish to die meant the physician could not have held the conviction that the request was voluntary and well considered.[66] The Court acquitted the physician of all charges, concluding that they complied with all the due care requirements under the *Review Procedures Act*.[67] Although this case, and the subsequent appellate decision of the Supreme Cassation Court, provides important insight regarding the obligations of physicians in administering VE/AS to mentally incompetent patients with an AED,[68] it provides little

[63] For discussion of the facts see Riley, Overbeek and van der Heide (n 51); *Annual Report 2016,* 54–8; Constance, Asscher and van de Vathorst (n 51) 72; *Annual Report 2019,* 94–6.
[64] Both the BPG and the HC Inspectorate initiated criminal proceedings and disciplinary proceedings respectively against the physician. At first instance, the disciplinary court concluded that the physician failed to terminate life with due care and issued a disciplinary warning. However, the criminal court acquitted the physician of all criminal charges: see District Court of The Hague, ECLI NL RBDHA 2019 10650, 11 September 2019. On appeal to the Supreme Cassation Court, the findings of the disciplinary court were overturned: see Hoge Raad Der Nederlanden, *Physician Permitted to Grant a Written Request for Euthanasia From Individuals Suffering from Advanced Dementia* (24 April 2020) (Webpage) <https://www.hogeraad.nl/actueel/nieuwsoverzicht/2020/april/physician-permitted/>; see also Constance, Asscher and van de Vathorst (n 51).
[65] District Court of The Hague, ECLI NL RBDHA 2019 10650, 11 September 2019, [3.3].
[66] Ibid.
[67] Ibid [5.3.2].
[68] See Supreme Court of the Hague, ECLI NL HR 2020 713, 21 April 2020; Hoge Raad Der Nederlanden, *Physician Permitted to Grant a Written Request for Euthanasia From Individuals Suffering from Advanced Dementia* (24 April 2020) (Web page) <https://www.hogeraad.nl/actueel/nieuwsoverzicht/2020/april/physician-permitted/>. For discussion on the role and development of the Supreme Cassation Court in the Netherlands, see RR Verkerk and

insight into the mechanics of an externally voluntary request, therefore, it will not be discussed further.[69]

It is clear from this discussion that the Committee plays a vital role in interpreting the scope and operation of the due care criteria under the *Review Procedures Act*. The Committee is empowered to determine whether the termination of life was done in accordance with the law, but, in cases of non-compliance, their decision is only provisional and suspected contraventions are referred to other bodies for investigation and potential disciplinary action or prosecution. Whether the physician properly ensured that the request for VE/AS was externally voluntary is an integral safeguard and contravention of this specific provision is considered a material breach of the law.

The Committee do not make their decision in a vacuum. They not only refer to prior Committee decisions in determining questions of compliance, but also refer to the legislative history and the case law that informed the underlying principles therein. Under the law, the Committee must publish an annual statistical report detailing the provision of VE/AS. The Committee have increasingly made excerpts of their decisions publicly available in English, with the goal of demonstrating how compliance with the legal criteria is determined. From this, insight into the technicalities of the parameters of external voluntariness can be gleaned, although this information stops short of providing meaningful discussion of the mechanics of the vital criterion.

Remco van Rhee, 'The Supreme Cassation Court of the Netherlands: Efficient Engineer for the Unity and Development of the Law' in Cornelis Hendrik (Remco) van Rhee and Yulin Fu (eds), *Supreme Courts in Transition in China and the West* (Springer, 2017) 77.

[69] For further discussion, see District Court of The Hague, ECLI NL RBDHA 2019 10650, 11 September 2019; Miller, Dresser and Kim (n 56); Constance, Asscher and van de Vathorst (n 51). Administration of VE/AS for patients with dementia remains a controversial issue in the Netherlands: see Legemaate and Bolt (n 44); van Delden (n 59); Hertogh (n 59).

Interpretation of external voluntariness under the *Review Procedures Act*

[11.30] Discussion on how the Committee interprets the legal due care criteria, especially cases that raise complex or novel questions, are available online through the Committee's website and in the Committee's annual statistical reports.[70] Since the *Review Procedures Act* came into force, the external voluntariness criterion has been the focus of little discussion and a physician has never faced prosecution or professional disciplinary action for failing to form a reasonable conviction that the request was externally voluntary.[71] Despite the lack of specific consideration given to this criterion, the information provided by the Committee's annual reports, as well as discussion in the existing scholarly literature, provide some insight into factors that have been deemed to be relevant when determining compliance with this element of the law.

As shown in Table 6, the *Review Procedures Act* itself does not define the word 'voluntary'. However, the Committee have interpreted this word as containing two separate limbs — internal and external voluntariness—[72] which, as outlined in **[11.10]**, requires consideration of different facts. The focus of this discussion is on external voluntariness as it is most closely aligned to the concept of undue influence, the term of choice in South Australian VAD bills.[73] External voluntariness looks beyond the individual patient themselves and focusses on whether an outside party, such as close family or friends, are

[70] See *Regional Euthanasia Review Committee* (Web Page) <https://english.euthanasiecommissie.nl/>.
[71] See Legemaate and Bolt (n 44) 454; see also Penney Lewis and Isra Black, 'Adherence to the Request Criterion in Jurisdictions where Assisted Dying is Lawful? A Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon and Switzerland' (2013) 41(4) *Journal of Law Medicine and Ethics* 885.
[72] Internal voluntariness focuses on the competence of the person requesting euthanasia. Critical to this element is the requirement for the patient to be decisionally competent. Decisional competence 'means that the patient is able to communicate intelligibly about his request for euthanasia and understand the relevant medical and other information. He must have insight into his condition: in other words he can assess his situation and the implications of euthanasia or alternative treatment. Finally, he must be able to make it clear why he wants euthanasia to be performed': see *Euthanasia Code,* 19. See also John Griffiths, 'Assisted-suicide in the Netherlands: The Chabot Case' (1995) 58(2) *Modern Law Review* 232.
[73] In South Australia, undue influence is recognised as a creation of equity — a separate jurisdiction to courts of common law — originating in Medieval England. Consequently, equity and its doctrines and remedies are not recognised in civil law jurisdictions, such as the Netherlands.

improperly pressuring the person to request VE/AS. The external voluntariness requirement operates to protect a voluntary decision by ensuring that the request for VE/AS is the patient's decision and not the product of another's will. The potential breadth of this term is ambiguous in the law itself; however, some guidance is available regarding the fundamental elements of this provision.

The most comprehensive statement provided by the Committee concerning external voluntariness is found in the *Euthanasia Code 2018*. Here, the Committee remarked that

> the request must have been made without any undue influence from others (external voluntariness). The physician must be satisfied that there has been no such influence. He should exercise particular caution when, for instance, a close relative of the patient becomes too overtly involved in the conversation between physician and patient, or repeatedly gives answers that the physician wishes to hear from the patient himself. It may then be necessary for the physician to speak with the patient privately. If a patient requests euthanasia partly because he feels he is a burden to others, the request may not necessarily be involuntary.[74]

Thus, according to the Committee, external pressure has been described as a form of undue influence and the terms were used synonymously here. However, it is uncertain whether undue influence has the same meaning in the Netherlands as is does under existing law in South Australia, or represents a difference in translation. Regarding this interpretation of 'external pressure', the Committee have not, beyond what was explicated in the above quote, provided a sufficient statement that establishes some broad parameters concerning what is undue influence or external pressure. Despite this semantic uncertainty, it is evident that the Committee perceives close family members as a potential source of influence or external pressure that could undermine the voluntary nature of a request for VE/AS, and physicians must be mindful of this fact. If suspicions arise, then consulting with the patient alone to confirm that the request is externally voluntary is necessary.

[74] *Euthanasia Code,* 19.

It is evident from the wording used in the *Review Procedures Act* that, for a request to be considered externally voluntary, it must come from the patient themselves. Article 2(1)(a) states that the physician 'holds the conviction that *the request by the patient* was voluntary and well-considered'.[75] The Committee have interpreted this broadly, indicating that a request can be made either orally, in writing, or by some other form of communication, but it must be communicated *by the patient*.[76] However, in cases where there is an AED and questions concerning the patient's competence arise, there must be a formal written AED, supported by ongoing historical discussions with treating physicians when the patient was still mentally competent.[77] In such circumstances, the physician must ascertain primarily from these written records that the request was externally voluntary. Whilst physicians need to be mindful that close family members may be a source of external pressure, thus potentially vitiating a voluntary decision, it does not flow that families are altogether excluded in discussions on voluntary euthanasia and assisted suicide.

In the existing literature, there is evidence indicating that discussions concerning VE/AS are not made in isolation but are the product of familial conversations in many circumstances.[78] The Committee/s are supportive of the role families play in the decision-making process. However, the vital issue that must be borne in mind by the physician is whether the decision remains that of the patient,[79] which is a question of fact and degree,

[75] *Review Procedures Act* (emphasis added).
[76] *Euthanasia Code*, 18.
[77]Regional Euthanasia Review Committee, *Annual Report 2017* (March 2018) 47–9 <https://english.euthanasiecommissie.nl/the-committees> ('*Annual Report 2017*').
[78] See *Euthanasia Code,* 18. For discussion on the consultation with family members when there is an AED, see District Court of The Hague, ECLI NL RBDHA 2019 10650, 11 September 2019; see also *Annual Report 2017,* 47–9 <https://english.euthanasiecommissie.nl/the-committees>.
[79] *Euthanasia Code,* 18.

determined on a case-by-case basis. One decision published by the Committee in 2003 provides some insight into external voluntariness in the context of familial discussions for voluntary euthanasia and assisted suicide.[80]

In this case, the physician had been in a clinical relationship with the patient for about a year prior to granting her request for (and administering) VE/AS.[81] The physician reported that during conversation(s) with the patient regarding their request, the patient's parents had exhibited some pressure on her to consent to the procedure. However, the physician reported that the pressure was not significant enough to vitiate the patient's will or interfere with the decision-making process.[82] It was not reported on what grounds the physician formed the reasonable conviction concerning the parents' acceptable pressure, which would have provided a clearer picture regarding how this opinion was formed.[83] The Committee, however, did not take issue with the physician's finding on this point, concluding that all due care criteria were met.[84] Whilst this finding falls short of providing meaningful insight into the technical or nuanced elements of external voluntariness, it indicates that some pressure can permissibly be exerted on persons to request VE/AS, with the threshold question being that it cannot interfere with the decision-making process. Given the inherent complexity involved in making a determination on external voluntariness in such a scenario, physicians would need to ensure that the factors that suggest external pressure is being exerted on a person do not outweigh the voluntariness of the decision. This appears to be an incredibly fine line to

[80] Regional Euthanasia Review Committee, *Annual Report 2003* (3 September 2004) 13 < https://english.euthanasiecommissie.nl/the-committees/documents/publications/annual-reports/2002/annual-reports/annual-reports>.
[81] Ibid.
[82] Ibid.
[83] Ibid.
[84] Ibid.

walk and, in recognition of this issue, the existence of a long-standing clinical relationship was perceived as pivotal for assessing the external voluntariness.

The Committee's position on this matter in the formative years of the *Review Procedures Act*[85] was that there had to be an existing physician-patient relationship in order for the physician to form a reasonable conviction that the request was externally voluntary. Clinical relationships that were solely confined to the performance of VE/AS were largely considered unacceptable as it was assumed that external voluntariness could not be adequately assessed under these circumstances.[86] It has not been made clear what the appropriate duration of a physician-patient relationship should be, but it was evident that the due care criteria 'presuppose some kind of clinical relationship with the patient'.[87] In 2002, a doctor who euthanised a patient after being in a clinical relationship with them for only one day was found to have failed to act with the requisite due care and the case was referred to the Board of Procurators-General.[88] Pertinent to the Committee's referral was, amongst other things, the length of the physician-patient relationship.[89] However, in 2012, end of life clinics ('SLK Clinics') were established in the Netherlands and their role was solely confined to the provision of VE/AS, meaning that a prior clinical relationship will not be possible and therefore cannot act as an indicia of appropriate conduct.

The SLK Clinics have their own team of VE/AS physicians and nurses who were solely responsible for assessing whether the patient's request meet the due care requirements.[90]

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[85] Regional Euthanasia Review Committee, *Annual Report 2002* (2003) 1–8 <https://www.euthanasiecommissie.nl/uitspraken/jaarverslagen/2002/nlendufr/nlendufr/jaarverslag-2002>.
[86] Ibid.
[87] Ibid 16.
[88] Ibid.
[89] Ibid; see also Theo Boer, 'Dialectics of Lead: Fifty Years of Dutch Euthanasia and its Lessons' (2018) 75(2) *International Journal of Environmental Studies* 239, 243–44.
[90] *Annual Report 2012*, 6.

According to their internal procedures, it is required that physicians have to consult with patients on several occasions to ascertain that the request was voluntary and well considered.[91] In 2012, the Committee commented on the obligations of SLK physicians, observing that the SLK

> physician who takes over the patient's treatment and becomes involved in the euthanasia procedure must take the time to become properly acquainted with the patient. Only in-depth, repeated consultations with the patient will enable the physician to assess whether the due care criteria [external voluntariness] are satisfied. It is impossible, however, to fix a minimum number of consultations required or a minimum time period in which these are to take place. This type of situation also calls for good communication between the physicians involved and a proper transfer of patient records.[92]

Therefore, in response to this new situation, the Committee established some guidance concerning the requirement for physicians to become acquainted with the patient to ensure that external voluntariness could be adequately assessed. However, as this was a deviation from the old rule, VE/AS performed by SLK physicians had been subject to additional scrutiny. The Committee, as a matter of policy, initially deemed all cases reported by SLK physicians as non-straightforward, thus requiring full discussion at monthly Committee meetings.[93] This position was short-lived, and, in 2015, the Committee indicated notifications received from SLK physicians were subject to the same procedure as other notifications, thus leaving determination of the case as straightforward or non-straightforward a matter for the Committee Secretary.[94]

The establishment of the SLK clinics, notably referred to by VE/AS critic Theo Boer as 'mobile euthanizing teams',[95] has not been accepted without critique. One main concern

[91] Ibid 6, 10–12.
[92] Ibid 11.
[93] *Annual Report 2013*, 9.
[94] See Okninski (n 42) 136.
[95] See Boer (n 89) 243.

is that the establishment of the SLK clinics has resulted in an erosion of the requirement that the physician-patient relationship be long-standing, thus compromising assessment of several of the due care criteria, including external voluntariness. However, further analysis of these criticisms is beyond the narrow focus of this discussion.[96] The key point to highlight with respect to the SLK clinics and their impact on external voluntariness is that the physician must be able to justify that they know the patient well enough to be able to form a reasonable conviction that the request was externally voluntary. There is no concrete rule on this point, and it is up to the physician, SLK or otherwise, to demonstrate to the Committee that they consulted with the patient enough to form this opinion and, in the context of the SLK clinics, this may prove more challenging than in the more traditional clinical environment.

Summary

[11.40] It is evident from this analysis of VE/AS in the Netherlands that the Committee is vested with 'enormous liberties' when it comes to interpreting the law, which is largely attributed to the 'open character of the due care criteria'.[97] While the Netherlands *may* have succeeded in making their review procedure process transparent and descriptive, there is a lack of information concerning the external voluntariness criterion. Upon review of the available literature on this specific provision, little could be learnt regarding how the Committee ascertain that the physician formed a reasonable conviction that the request was externally voluntary.[98]

[96] For discussion see Boer (n 89) 239; Theo Boer, 'Following the Guide? Why Dutch and Belgian Experiences on Assisted Dying Should Concern Other Countries' (2016) 131 *Zadok Perspectives* 5.
[97] See Boer (n 89) 245; see also Judith Reitjens et al, 'Two Decades of Research on Euthanasia from the Netherlands. What Have we Learnt and What Questions Remain?' (2009) 6 *Journal of Bioethical Inquiry* 271.
[98] A significant body of empirical research has been undertaken over the last several decades that aims to provide insight into the decision-making process of physicians when granting or refusing requests for

It was highlighted in **[11.20]** of this Chapter that the BPG view non-compliance with this due care criterion a material breach of the law, which is considered a significant contravention. Despite this position, little is known about external voluntariness beyond what was discussed in this chapter. Physicians are not required to forward information concerning refused requests for VE/AS — the position in several jurisdictions — which is likely to provide important insight into what factors the physician deemed important in concluding that the request was not externally voluntary. Despite this limitation, some basic elements have been elucidated by the Committee, which are deemed important when independent review of the case is performed.

These broad elements were that the physician had to be mindful of any undue influence/external pressure exerted on the patient when discussing or making a request for VE/AS whether actual or through an AED. The decisive issue for the physician is that the request must originate from the patient themselves. Moreover, whilst families are not excluded from discussions regarding VE/AS and some familial pressure is acceptable, the key point is that this cannot interfere with the decision-making process or vitiate the voluntariness of the request. Furthermore, physicians can be in a clinical relationship with patients that is solely confined to the administration of VE/AS. However, they must consult with the patient enough times to form a reasonable conviction that the request

voluntary euthanasia and assisted suicide. Whilst this research provides insight into the physician's decision-making process regarding interpretation of the due care criteria, external voluntariness remains overlooked and has not been subject to critical examination. For general discussion on granted and refused requests, see especially Ilinka Haverkate et al, 'Refused and Granted Requests for Euthanasia and Assisted Suicide in the Netherlands: Interview Study with Structured Questionnaire' (2000) 321 *British Medical Journal* 865; Judith Reitjens et al, 'Two Decades of Research on Euthanasia from the Netherlands. What Have we Learnt and What Questions Remain?' (2009) 6 *Journal of Bioethical Inquiry* 271; Arianne Brinkman-Stoppelenburg et al, 'Obligatory Consultation of an Independent Physician on Euthanasia Requests in the Netherlands: What Influences the SCEN Physicians Judgment of the Legal Requirements of Due Care?' (2014) 115 *Health Policy* 75; H Roeline, W Pasman, Dick L Willems and Bregje D Onwuteaka-Philipsen, 'What happens after a request for Euthanasia is Refused? Qualitative Interviews with Patients, Relatives and Physicians' (2013) 92 *Patient Education and Counseling* 313; Marijke C Jansen-van der Weide, Bregje D. Onwuteaka-Philipsen and Gerrit van der Wal, 'Granted, Undecided, Withdrawn and refused Requests for Euthanasia and Physician-Assisted Suicide' (2005) 165 *Archives of Internal Medicine* 1698.

was externally voluntary, a matter for which the law does not provide any guidance and leaves this at the discretion of the physician. What can be said regarding this criterion is that it appears to be a subjective test, not measured against any objective criteria. Furthermore, it is dynamic in nature and reliant on the physician's knowledge of the patient and their evaluation of their individual personal circumstances. Thus, while the outer limits of external voluntariness cannot be described, some foundational principles exist under the *Review Procedures Act* and these serve as a basic yardstick on this issue. The position under the *Review Procedures Act* concerning the general lack of clarity and certainty around the external voluntariness protection is consistent with other jurisdictions examined — and yet to be examined — in Part 2. It is evident that there is broad recognition of the need to protect a voluntary decision from external pressure; however, there is a lack of detailed discussion articulating the minutiae of this requirement. This represents the core challenge which is the substance of this thesis. Now that the South Australian legislature has legalised VAD, the legislative requirements that aim to ensure that the request is externally voluntary and free from external pressure, not only in the Netherlands but elsewhere too, must be critically reviewed. This will be considered in more detail in Chapter 18.

Voluntary and not the result of external pressure: pivotal requirements for lawful euthanasia in Belgium

[12.10] The *Belgian Act on Euthanasia of May 28 2002* (‘*Euthanasia Act’*) came into force on 23 September 2002, and, consistent with the position adopted in the jurisdictions discussed above, protection of a voluntary decision is a pivotal legislative requirement. Physicians are granted immunity from criminal prosecution if they administer voluntary euthanasia (‘VE’) according to the conditions and procedures stipulated in the *Euthanasia Act*.[1] Several substantive and procedural criteria have been established under the law. However, the provision relevant to this discussion is that the law requires the physician to ensure that the request was voluntary and not the result of any external pressure.[2]

As outlined in Table 6 above, the *Euthanasia Act* itself does not define ’voluntary’ or ‘external pressure’, nor provide meaningful insight concerning how this determination is made. The legislation does, however, require that both the patient and the ‘physician must come to the *belief*… that the patient’s request is completely voluntary’,[3] thus providing some guidance by establishing the degree of conviction required, with the threshold test

[1] An official translation of the *Belgian Act on Euthanasia of 28 May 2002 (‘Euthanasia Act’)* is provided in Guenter Lewy, *Assisted Death in Europe and America: Four Regimes and their Lessons* (Oxford University Press, 2011) 272–81. Since the *Euthanasia Act* came into force it has been amended twice, with the latest amendment in 2014 which removed all age restrictions for voluntary euthanasia (‘VE’): see especially Herman Nys, ‘A Discussion of the Legal Rules on Euthanasia in Belgium Briefly Compared with the Rules in Luxembourg and the Netherlands’ in David Albert Jones, Chris Gastmans and Calum MacKellar (eds) *Euthanasia and Assisted Suicide: Lessons from Belgium* (Cambridge University Press, 2017) 7–25; see also Penney Lewis, ‘Euthanasia in Belgium Five Years After Legalisation’ (2009) 16(2) *European Journal of Health Law* 125.

[2] *Euthanasia Act* s 3(1). For a brief overview of the legislative history of the *Euthanasia Act:* see Lewy (n 1) 69–87; see also Calum MacKellar, ‘Some Possible Consequences Arising from the Normalisation of Euthanasia in Belgium’ in Jones, Gastmans and MacKellar (n 1) 221–23; John Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press, 2nd ed, 2018) 183–97.

[3] *Euthanasia Act* s 3(2)(1) [own emphasis].

being 'belief'. However, this falls short of providing clarity and guidance into this test, instead highlighting that this is a difficult test as it is internal and subjective.

Belgium has one of the most liberal VE regimes in the world, with access to VE permitted for persons with terminal or non-terminal conditions.[4] To reflect these differing circumstances, Belgium have established two separate approaches to safeguarding a voluntary request depending on whether the person is expected to die in the near future or not. In cases where death is likely to occur in the near future, it is the sole obligation of the physician who administers VE to form the belief that the request was voluntary and not the result of external pressure.[5] Whilst it is mandatory for the euthanising physician to consult a second independent physician, their opinion is limited to clinical matters and not questions of external pressure, which Keown considers a 'remarkable oversight',[6] as independent verification of the voluntary nature of the request would heighten protection for patients by ensuring that the decision is voluntary. However, a unique feature of the *Euthanasia Act* is that it appears to establish the bare minimum criteria for physicians to lawfully administer VE. Section 3(2), which contains the list of conditions and procedures physicians must satisfy prior to administering VE (ss 3(2)(1)–(6)),[7] stipulates that '*without prejudice to any additional conditions imposed by the physician* on his/her own action, before carrying out euthanasia, he/she must in each case … [ensure they have satisfied all conditions in ss 3(2)(1)–(6)]'.[8] Therefore, the inclusion of this condition appears to permit the physician administering euthanasia to set additional safeguards beyond what is mandated in the law, which could extend to independent verification that

[4] *Euthanasia Act* s 3(1). Under the *Euthanasia Act* minors are permitted to request voluntary euthanasia; however, such requests are subject to additional, stricter conditions. Voluntary euthanasia for minors are beyond the scope of this thesis: see Herman Nys, 'A Discussion of the Legal Rules on Euthanasia in Belgium Briefly Compared with the Rules in Luxembourg and the Netherlands' in Jones, Gastmans and MacKellar (n 1) 18–9.
[5] *Euthanasia Act* ss 3(1), 3(2)(1).
[6] See *Euthanasia Act* s 2(3); see Keown (n 2) 293.
[7] See *Euthanasia Act* ss 3(2)(1)–(6).
[8] Ibid s 3(2).

the request was voluntary and not the result of any external pressure. This is, however, only a discretionary requirement and there is little evidence to suggest that this option has been implemented by physicians.

In situations where death is unlikely to occur in the near future, additional caution is required in assessing questions of voluntariness and the law establishes a more robust approach.[9] In these circumstances, another independent physician, either a psychiatrist or specialist in the disorder in question, must be consulted to personally examine the patient to ensure that the request was voluntary.[10] However, this examination is limited to consideration of voluntariness only and not external pressure. This approach is somewhat perplexing. The terms 'voluntary' and 'external pressure' have been included in s 3(1) but the 'external pressure' requirement has been omitted in s 3(3)(1).[11] Similar inconsistencies with the law have been highlighted in the scholarly literature. For instance, Nys directs his attention to the relationship between the word 'voluntary' and the phrase 'not the result of any external pressure',[12] arguing that 'reference to "external pressure" adds almost nothing, since any request that is the result of external pressure cannot, by definition, be voluntary'.[13] In a similar vein, Keown challenges the open nature of the *Euthanasia Act,* especially lack of specificity regarding the 'voluntary' criterion, asking whether a request is still voluntary if VE is requested by relatives and not the patient themself.[14] While Keown's question is rhetorical, he raises a valid point regarding the lack of clarity concerning this provision. Voluntariness and the absence of external pressure are pivotal elements of the *Euthanasia Act*, which aim to protect patients against improper pressure to request VE. However, in the absence of clear direction regarding

[9] For an overview of the (increasing) number of voluntary euthanasia administered on persons not expected to die in the near future, see Montero in Jones, Gastmans and MacKellar (n 1) 45.
[10] *Euthanasia Act* s 3(3)(1).
[11] See Table 6.
[12] *Euthanasia Act* s 3(1).
[13] Nys in Jones, Gastmans and MacKellar (n 1) 15.
[14] Keown (n 2) 289.

these key requirements, these tests are likely to be arbitrary and ambiguous. This is analogous to an art critic reviewing an oil painting blindfolded — they may understand from texture of the dried paint that it is an oil painting but cannot provide any meaningful description of it as their vision is occluded, thus rendering their opinion null. However, despite these issues, it is evident that in cases where death is not imminent, the requirement to consider the voluntary nature of the request is held to a higher standard than in cases where death is deemed to be imminent.[15]

It is beyond the scope of this thesis to attempt to resolve the matters in relation to lack of clarity in the *Euthanasia Act*. This discussion is important nonetheless, as it serves to highlight concerns that have been raised and should be utilised to inform the debate unfolding in South Australia who are now in the process of implementing the *Voluntary Assisted Dying Act 2021* (SA). Upon examination of the *Euthanasia Act* itself and the secondary materials available in English,[16] it is difficult to ascertain how parliament intended these pivotal safeguards to operate. Therefore, it is not possible to provide a detailed discussion regarding a definition of 'voluntary' and 'not the result of external pressure'. Moreover, unlike the position in the Netherlands where the *Review Procedures Act* was preceded and informed by several seminal cases, VE in Belgium occurred in a truncated period of time through the legislature.[17] Additionally, provisions of the *Euthanasia Act* have been subject to little judicial consideration and only a few physicians have ever been prosecuted for allegedly failing to adhere to the legislative requirements, albeit unsuccessfully.[18] The *Euthanasia Act*, however, establishes the Federal Commission for Euthanasia Control and Evaluation, who act in response to a mandatory reporting

[15] Keown has also voiced concern regarding the lack of specificity of several pivotal terms in the *Euthanasia Act*, including what exactly is considered a voluntary decision: see Keown (n 2) 289.
[16] Keown (n 2); Jones, Gastmans and MacKellar (eds) (n 1); Lewy (n 1).
[17] Keown (n 2) 281-96.
[18] See **[12.30]**.

process to determine whether VE was performed within the parameters of the legislative framework. It is at this point where it is determined whether the physician adequately ensured that the request was voluntary and not the result of any external pressure.

Role of the Federal Commission for Euthanasia Control and Evaluation under the *Euthanasia Act*

[12.20] The act of reporting cases of VE is a pivotal requirement under the *Euthanasia Act*, as 'notification is an explicit requirement of legality: the physician, who does not respect the obligation to notify, commits a criminal offence, which is murder in Belgium'.[19] Thus, VE remains a criminal offence in Belgium unless it is performed by a physician who adheres to the legal requirements stipulated by the *Euthanasia Act*.[20] The *Federale de Controle et d'evaluation de l'euthanasie* (Federal Commission for Euthanasia Control and Evaluation ('the Commission'))[21] are responsible for, amongst other things, determining whether reported cases of VE complied with the legal criteria. This includes determination of whether the physician properly formed the belief that the request was voluntary and not the result of any external pressure.[22]

The *Euthanasia Act* is specific concerning the composition of the Commission, requiring it be comprised of 16 members, predominantly experts in medicine and law.[23] Of the 16 members, eight

[19] Keown (n 2) 300.
[20] Ibid; Nys in Jones, Gastmans and Mackellar (n 1) 11.
[21] See Sante Publique, Securite de le Chaine Alimentaire et Environment, *Commission Federale de Controle et d'evaluation de l'euthanasie* (Web Page, 4 November 2020) <https://organesdeconcertation.sante.belgique.be/fr/organe-d%27avis-et-de-concertation/commission-federale-de-controle-et-devaluation-de-leuthanasie>.
[22] Ibid.
[23] *Euthanasia Act* s 6(2).

> are doctors of medicine, of whom at least four are professors at a university in Belgium. Four members are professors of law at a university in Belgium, or practising lawyers [and] four members are drawn from groups that deal with the problem of incurably ill patients.[24]

Therefore, the standard procedure for all reported cases is that they are reviewed through a multi-disciplinary lens. Additionally, cases must be reported by the euthanising physician to the Commission within four working days of administration,[25] thus making the review procedure retrospective. The *Euthanasia Act* prescribes the reporting procedure, including drafting the registration form physicians must submit to the Commission, which consists of two separate parts.[26] This two-part feature is important to the review process because anonymity of both patient and physician is a key protection built into the *Euthanasia Act*.[27] Part one of the registration form is sealed and contains identifying information of both patient and physician.[28] This information remains protected unless the Committee vote to revoke it, which can only occur in cases where compliance with the statutory criteria cannot be ascertained. Part two of the registration form requires the physician to detail how they complied with all the legislative requirements prior to administering VE. Of significance to this discussion is the requirement that the physician explicitly justifies 'the elements underlying the assurance that the request was voluntary … and not the result of external pressure'.[29] If it cannot be determined by the physician's report that they properly considered that the request was voluntary and not the result of external pressure, the Commission can vote to revoke anonymity.[30] If this circumstance arises, the Commission has the power to request additional information from the physician to facilitate their review process.[31] The

[24] Ibid.
[25] Ibid s 5.
[26] Ibid s 5.
[27] Ibid ss 7, 8.
[28] Ibid s 7; see also Keown (n 2) 298–325.
[29] *Euthanasia Act* s 7.
[30] Ibid ss 7, 8.
[31] Ibid s 8.

Commission is not vested with jurisdiction to issue penalties for cases of non-compliance with the law, and such cases must be referred to the public prosecutor for determination. However, the decision to refer is predicated on a two-thirds majority vote, if 'the commission is of the opinion that the conditions laid down in the [*Euthanasia Act*] have not been fulfilled, then it turns the case over to the public prosecutor'.[32] Since the implementation of the *Euthanasia Act*, only a handful of doctors have been prosecuted, albeit unsuccessfully.[33]

In order to ensure transparency concerning the practice of VE in Belgium, the Commission are required to table a report in parliament concerning the practice of VE every two years.[34] However, in contrast to the procedure adopted in the Netherlands where selected de-identified case reports by the Committee are published online, individual case reports of the Commission are confidential. Therefore, analysis of VE in Belgium is limited to a descriptive statistical overview.[35] Furthermore, the Commission do not reproduce a copy

[32] Two-thirds of Committee members must vote in favour of the case being referred: see *Euthanasia Act* s 8.
[33] See 'Euthanasiezaak voor het eerst aan Justitie doorgesprrld', *De Standaard*, (Online, 28 October 2015) <http://www.standaard.be/cnt/dmf20151028_01943198>; 'Belgian Euthanasia Doctor Could Face Criminal Charges', *SBS* (Online, 29 October 2015) <http://www.sbs.com.au/news/dateline/article/2015/10/29/belgian-euthanasia-doctor-could-face-criminal-charges>; Sigrid Dierickx et al, 'Euthanasia in Belgium: Trends in Reported Cases Between 2003 and 2013' (2016) 188(16) *Canadian Medical Association Journal*, 408, 412; 'Allow me to Die: None of us Know When Our Time is up', *Dateline* (SBS Television, 2015) <https://www.sbs.com.au/ondemand/video/525605443844/allow-me-to-die>; Keown (n 2) 311; Michael Day, 'Three Belgian Doctors are Investigated Over Euthanasia of Woman with Asperger's' (2018) 363 *British Medical Journal* 5106; Charlotte Wilson et al, 'First Criminal Investigation into Assisted Dying in Europe' (2019) 45(2) *Journal of Medical Ethics* 147; Rory Watson, 'Assisted Dying: Belgian Doctors Stand Trial in Landmark Case' (2020) 368 *British Medical Journal* 259; Michael Cook, 'Dramatic Euthanasia Trial Ends in Acquittal for all Three Belgian Doctors' *BioEdge* (Web Page, 1 February 2020) <https://www.bioedge.org/bioethics/dramatic-euthanasia-trial-ends-in-acquittal-for-all-three-belgian-doctors/13314>; Michael Cook, 'Belgian Trial is Unveiling Dark Back Story to Euthanasia Death of Tine Nys' *BioEdge* (Web Page, 26 January 2020) <https://www.bioedge.org/bioethics/belgian-trial-is-unveiling-dark-back-story-to-euthanasia-death-of-tine-nys/13305>; Michael Cook, 'Belgian Authorities Investigation Allegedly Illegal Euthanasia Deaths' *BioEdge* (Web Page, 29 November 2020) <https://www.bioedge.org/bioethics/belgian-authorities-investigating-allegedly-illegal-euthanasia-deaths/13636?utm_source=BioEdge&utm_campaign=6cde82519b-EMAIL_CAMPAIGN_2020_11_29_10_54&utm_medium=email&utm_term=0_76ab23e62c-6cde82519b-124726139>.
[34] *Euthanasia Act* s 9.
[35] See Dierickx et al (n 33) 408.

of their report in English,[36] it is, therefore, difficult to provide an in-depth analysis or critique in this overview discussion.[37]

The review procedure adopted in Belgium has not been accepted uncritically. For example, Griffiths et al argue that 'a Commission whose *raison d'etre* is to produce transparency and thereby maintain confidence in euthanasia practice, itself suffers from a regrettable absence of transparency'.[38] Similarly, Nys remarks that

> the Commission is not in a position to exercise the degree of control it should be exercising. It was a single body, comprised of volunteers, to review 2, 000 cases per year and it was 'nearly impossible' to check each case as it should be checked. That was the 'main problem' with the law. Additionally, the Commission lacked transparency: unlike the Dutch review committees it did not publish the reasons for its decisions.[39]

Despite these ostensible limitations with the review procedure, there is a considerable amount of discussion in the existing scholarly literature on the Commission's biennial reports and the practice of voluntary euthanasia in Belgium.[40] However, while the reports

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[36] See Sante Publique, Securite de le Chaine Alimentaire et Environment, *Commission Federale de Controle et d'evaluation de l'euthanasie* (Web Page, 4 November 2020) <https://organesdeconcertation.sante.belgique.be/fr/organe-d%27avis-et-de-concertation/commission-federale-de-controle-et-devaluation-de-leuthanasie>.

[37] There is discussion in the existing scholarly literature on cases of VE which provide insight into reported cases and trends regarding VE in Belgium: see especially Dierickx et al (n 33); see also below n 40.

[38] John Griffiths, Heleen Weyers and Maurice Adams, *Euthanasia and the Law in Europe* (Hart Publishing Ltd, 2008) 343.

[39] Keown (n 2) 305-06.

[40] See especially Tinne Smets et al 'Legal Euthanasia in Belgium: Characteristics of all Reported Euthanasia Cases' (2010) 48(2) *Medical Care* 187; Tinne Smets et al, 'The Medical Practice of Euthanasia in Belgium and The Netherlands: Legal Notification, Control and Evaluation' (2009) 90 *Health Policy* 181; Sigrid Dierickx et al, 'Euthanasia in Belgium: Trends in Reported Cases between 2003 and 2013' (2016) 188(16) *Canadian Medical Association Journal* 407; Dierickx et al (n 33); Sigrid Dierickx et al, 'Commonalities and Differences in legal euthanasia and physician-assisted suicide in three Countries: A Population-Level Comparison' (2020) 65 *International Journal of Public Health* 65; Owen Dyer, Caroline White and Aser Garcia Rada, 'Assisted Dying: Law and Practice around the World' (2015) 351 *British Medical Journal*; Joachim Cohen et al 'Nationwide Survey to Evaluate the Decision-making Process in Euthanasia Requests in Belgium: Do Specifically Trained 2nd Physician Improve Quality of Consultation?' (2014) 14 *BMC Health Services Research*; Yanna Van Wesemael, et al 'Process and Outcomes of Euthanasia Requests Under the Belgian Act on Euthanasia: A Nationwide Survey' (2011) 42(5) *Journal of Pain and Symptom Management* 721; Mette Rurup et al, 'The First Five Years of Euthanasia Legislation in Belgium and the Netherlands: Description and Comparison of Cases' (2011) 26(1) *Palliative Medicine* 43; Penny Lewis and Isra Black, 'Adherence to the Request Criterion in Jurisdictions Where Assisted Dying is Lawful? A Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon and Switzerland' (2013) *Human Rights and Disability* 885; Julia Nicol and Marlisa Tiedemann, 'Euthanasia and Assisted Suicide: The Law in Selected Countries' (Publication No. 2015-116-E, Library of Parliament, Canada, 2015).

are beneficial to a degree as they provide a statistical snapshot of the practice of VE in Belgium, they cannot remedy the deficiencies concerning the brevity of the information contained therein. Thus, while it can be said that the Commission are vested with considerable power to interpret the criteria under the *Euthanasia Act*, little is known about how they exercise that power and interpret the substantive provisions of the *Euthanasia Act*.

Interpretation of 'voluntary and not the result of any external pressure'

[12.30] As discussed in **[12.20]**, the Commission are mandated with the task of determining whether there has been compliance with the *Euthanasia Act*. However, their mandate goes beyond mere assessment of compliance with the procedural criteria and extends to interpretation of the substantive statutory criteria. Ensuring that the request was voluntary and not the result of external pressure is a substantive safeguard under the law and is the most relevant to this thesis. However, the Committee have refrained from releasing any additional information that would facilitate understanding of the key elements of this provision. Whilst there is a good volume of discussion on voluntary euthanasia in Belgium in the existing scholarly literature, this information does not provide meaningful insight into the mechanics of these key criteria, which is the focus of this discussion. In the absence of information on this point, interpretation of 'voluntary' and 'not the result of external pressure' cannot be provided. Thus, insight into the key elements of a request that is voluntary and not the result of external pressure remains unclear. What is evident is that this is a discretionary test to be solely determined by the physician that need not satisfy any objective criteria. Failure to properly consider this provision can result in criminal proceedings being initiated against the physician, although, to date, no physician has faced prosecution for breaching this provision.

The ambiguity and lack of certainty surrounding this pivotal statutory protection is not unique to Belgium. There is a consistent lack of explication on this statutory protection in all jurisdictions considered so far in Part 2, which is reflective of an emerging pattern. The sustained silence is perhaps indicative of a larger issue — that is, the inherent complexity involved in safeguarding something as abstract as voluntariness. However, regardless of the underlying reasons for adopting this position of silence, the gravity of VAD demands that greater steps should be taken to clarify how this test translates into a meaningful protection. As it stands, the silence does not paint a convincing picture that voluntariness and the absence of a behaviour that operates to undermine it, such as undue influence or external pressure, work well as statutory safeguards in practice. This evidential limitation needs to be borne in mind by the South Australian legislature when debating implementation of VAD.

Summary

[12.40] At the time of writing, the *Euthanasia Act* has been in force for nearly 20 years. One of the key legislative safeguards is that the euthanising physician must form the belief that the request was voluntary and not the result of any external pressure. Failure to do so can lead to criminal prosecution. Whilst this appears to be a promising protection of patients, careful review of the primary and secondary sources of law and the broader empirical research reveals that little is known about these key provisions in Belgium which challenges their efficacy. There is limited discussion on this aspect of the law. It is, however, important to address the limitations of this analysis.

The limited narrative around the 'voluntary and free from external pressure' requirement can itself be interpreted as revealing a lack of engagement with the requirement and

reflect an absence of meaningful protection. However, it must also be acknowledged that there is a limitation to the present analysis and there is potential for some narrative to have been overlooked as it has been confined to a review of the material available in English. Whilst the majority of the resources relied upon were peer-reviewed official translations of the original sources of information, such as the biennial reports released by the Commission,[41] broader information may exist on this point in French or Flemish which could impact this discussion. Despite this caveat, it is nonetheless evident that safeguarding against external pressure has the potential to be a key protection but important elements of this statutory safeguard are opaque and it remains to be seen how broad, or not, this protection really is. This is reflected across most of the jurisdictions under consideration here.

[41] See, eg, above n 40.

Made voluntarily and does not result from external pressure: pivotal requirements for lawful voluntary euthanasia and assisted suicide in Luxembourg

[13.10] The Grand Duchy of Luxembourg decriminalised voluntary euthanasia and assisted suicide ('VE/AS') by enacting the *Law of 16 March 2009 on Euthanasia and Assisted Suicide* ('*EAS Act*').[1] The *EAS Act* provides physicians with immunity from civil proceedings and criminal prosecution if they perform VE/AS subject to the procedures and conditions established by the law.[2] Whilst the law has now been operational in Luxembourg for over 12 years, it was not universally supported, passing with a bare majority in parliament despite public support for reform in this area.[3] Consequently, the *EAS Act* caused political uproar in the predominantly Catholic country and, as Watson explains, 'provok[ed] one of the most heated political debates in the Grand Duchy's history … [which] even led to a change in the national constitution after the Grand Duke Henri refused to sign the new bill into law'.[4] After this controversial start, the *EAS Act* came into force on 1 April 2009.

The *EAS Act* was one of two statutes passed simultaneously that sought to regulate and broaden end-of-life options. Whilst recognising the need to provide greater choice at the end-of-life, the legislature also sought to ensure that the development of traditional

[1] An official English translation of the law is available at Le Government Du Grand-Duche De Luxembourg, *L'euthanasie et l'assistance au suicide: 25 Questions, 25 Responses'* (Web Page, June 2010) <https://sante.public.lu/fr/publications/e/euthanasie-assistance-suicide-questions-reponses-fr-de-pt-en/index.html> ('*EAS Act*'); see also Rory Watson, 'Luxembourg is to Allow Euthanasia from 1 April' (2009) 338 *British Medical Journal* 1248.
[2] *EAS Act* art 2.
[3] Watson (n 1) 1248.
[4] Ibid. The Grand Duke's refusal to sign the EAS Bill into law resulted in parliament amending the Constitution, reducing the power of the monarchy to a purely ceremonial role. See also Luc Frieden, 'Luxembourg: Parliament Abolishes Royal Confirmation of Laws' (2009) 7(3) *International Journal of Constitutional Law* 539.

palliative care was not impeded by the enactment of VE/AS legislation.[5] This did not, however, give rise to an obligation for the patient to first exhaust all palliative care options prior to making a request for VE/AS. Instead, it obligated physicians to explain to the patient requesting VE/AS the 'possibilities offered by palliative care and the consequences'.[6]

The *EAS Act* largely mirrors the Belgian model in terms of safeguards and procedure;[7] therefore, safeguarding a voluntary decision is a core formal criterion. Under the law, a person can make either an active or advance request for VE/AS and the requirement to safeguard a voluntary decision is the same in both instances.[8] Physicians must ensure that, inter alia, 'the request is made voluntarily … and does not result from external pressure'.[9]

As shown in Table 6, the degree of conviction required under the law is 'belief' that the request is voluntary and does not result from external pressure. These terms are not defined in the legislation itself nor the extraneous material available — a consistent position with all jurisdictions discussed here.[10] Similar to the position in Belgium, a second independent physician is required to consult on the medical aspects of the patient's illness and not the voluntariness of the request.[11] The *EAS Act* does, however,

[5] See Le Government Du Grand-Duche De Luxembourg, *L'euthanasie et l'assistance au suicide: 25 Questions, 25 Responses'* (Web Page, June 2010) 10–11 <https://sante.public.lu/fr/publications/e/euthanasie-assistance-suicide-questions-reponses-fr-de-pt-en/index.html> ('25 Questions, 25 Réponses on VE').
[6] *EAS Act* art 2(1)(2); see also 25 Questions, 25 Réponses on VE (n 5).
[7] For an overview of the similarities and key differences between the Belgian and Luxembourg legislation see Nicole Steck et al, 'Euthanasia and Assisted Suicide in Selected European Countries and US States' (2013) 51(10) *Medical Care* 938; Herman Nys, 'A Discussion of the Legal Rules on Euthanasia in Belgium Briefly Compared with the Rules in Luxembourg and the Netherlands' in David Jones, Chris Gastmans and David MacKellar, *Euthanasia and Assisted Suicide: Lessons From Belgium* (Cambridge University Press, 2018) 7-25; see also Watson (n 1).
[8] *EAS Act* arts 2, 4.
[9] Ibid art 2.
[10] See, eg, 25 Questions, 25 Réponses on VE (n 5).
[11] Ibid.

require the physician to interview the patient's care team and appointed person of trust regarding the request, unless the patient objects to such consultations.[12] The inclusion of this provision is unique to Luxembourg, as Belgium's *Euthanasia Act* does not contain an analogous requirement. Therefore, the *EAS Act* potentially goes further by adding another layer of protection for a voluntary decision. Whilst the law is not explicit regarding the nature of these consultations, questions concerning the volition of the request may be a subject of further discussion. Furthermore, physicians may consult with an expert of their choice regarding any aspect of the patient's request for VE/AS.[13] This provision has been deliberately left broad, leaving this at the physician's discretion, should the need to engage with another expert arise. In order to ensure that VE/AS is administered lawfully, an oversight committee reviews all reported cases of VE/AS.

The role of the National Commission for Control and Assessment under the *EAS Act*

[13.20] Compliance determination is performed retrospectively by the National Commission for Control and Assessment ('the Commission'), an independent statutory body established under the *EAS Act*.[14] The Commission functions 'as a kind of buffer between the physician and prosecutor, based on the idea that a physician does not want to (nor should) be dealt with in the atmosphere of criminality'.[15]

The review procedure for VE/AS in Luxembourg is largely consistent with the review framework implemented in Belgium,[16] and, as observed with respect to Belgium, the

[12] *EAS Act* arts 2(1)(2)(4), 2(1)(2)(5).
[13] Ibid art 3.
[14] Ibid arts 5, 6.
[15] Nys in Jones, Gastmans and MacKellar (n 7) 23.
[16] Watson (n 1).

multi-disciplinary composition of the Commission and anonymity of both patient and physician are paramount protections built into the law.[17] The Commission is comprised of nine members predominantly from the medical and legal professions.[18] As all requests for VE/AS must be made in writing, the Commission is responsible for drafting the official declaration form.[19] The declaration form consists of two separate sections.[20] The first section is confidential and contains the identifying information of the treating doctor and patient and is sealed by the doctor after completion.[21] The second section of the declaration requires the doctor to demonstrate how they complied with the statutory criteria.[22] It is on this part of the form where the physician is required to explain 'the factors providing an assurance that the request was made voluntarily … and without external pressure',[23] which must be submitted within eight days.[24]

Anonymity, although a key protection, is not absolute and can be revoked in circumstances where compliance with the legislative criteria cannot be ascertained.[25] The Commission enjoys broad power to determine compliance with the legislative criteria; however, it cannot penalise physicians in cases of non-compliance.[26] Such cases are referred to either the Medical Council or the Public Prosecutor.[27] Whether the case is referred to the public prosecutor or not is entirely dependent upon the suspected breach, as the *EAS Act* is specific concerning which cases will be referred for potential criminal prosecution.[28]

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[17] *EAS Act* arts 6(2), 7.
[18] Ibid art 6(2).
[19] Ibid art 7.
[20] Ibid.
[21] Ibid.
[22] Ibid art 7.
[23] Ibid.
[24] Ibid art 5.
[25] Ibid art 8.
[26] Ibid.
[27] Ibid.
[28] Ibid.

The law distinguishes between non-compliance with the substantive requirements of the law and non-compliance with the procedural requirements, with a breach of the former category viewed as more serious, attracting referral to the public prosecutor.[29] Failure to properly consider that the request was made voluntarily and does not result from external pressure are substantive criteria, and therefore, will be referred to the public prosecutor for investigation.[30] The fact that contravention of this requirement is deemed a serious breach reflects an understanding of the significance of independent decision-making and a respect for individual freedom of choice. The *EAS Act* is not as specific concerning referrals to the Medical Council for non-compliance with the law, as all cases of non-compliance are subject to referral for potential disciplinary action.[31] The Commission must produce a biennial report detailing the administration of VE/AS for the previous two years.[32] In the 2017–2018 report, the Commission indicated that, at that time, 71 cases of VE/AS have been reported and reviewed since the law came into force.[33]

Interpretation of 'voluntary and does not result from external pressure' under the *EAS Act*

[13.30] As considered in **[13.20]**, safeguarding voluntariness is a substantive safeguard. In the *EAS Act*, these terms have not been defined. However, it is a legal requirement that VE/AS can only be granted if there is a 'close' physician-patient relationship, with the law

[29] Ibid.
[30] Ibid arts 2(1)(2), 8.
[31] Ibid art 8.
[32] Ibid arts 9(a)–(c).
[33] Commission nationale de Controle at d'Evaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide, *Cinqueme Rapport a l'attention de la Chambre des Deputes (Annees 2017 et 2018)* (Web Page, 2019) 3 <https://sante.public.lu/fr/publications/r/rapport-loi-euthanasie-2017-2018/index.html >; Hannah Brenton, 'A Decade on: More than 70 People Choose Euthanasia in Luxembourg', *Luxembourg Times* (online, 30 May 2019) <https://luxtimes.lu/luxembourg/37382-a-decade-on-more-than-70-people-choose-euthanasia-in-luxembourg>.

requiring that the physician must have 'several interviews' with the patient.[34] The impetus behind this requirement has been addressed by the Ministry of Social Security and the Commission on their website, where they explain that a longstanding physician-patient relationship is conducive to the physician determining that the request was 'made freely and without force'.[35] The legislature have stopped short of prescribing the specific length of relationship, with this determined on a case-by-case basis, suggesting that this is a meaningful relationship as opposed to one defined purely by length of time. However, in the absence of any evidence to suggest that this has been subject to discussion by the Commission, the courts or the Medical Council,[36] it is not possible to engage in further analysis on this point. The most than can be said with certainty is that it is a basic condition that assessment of voluntariness and freedom from external pressure requires a pre-existing relationship between the physician and patient.

As discussed in **[13.20]**, the Commission are responsible for reviewing cases to ensure VE/AS was performed in accordance with the legal requirements. They are, therefore, vested with broad power to interpret the substantive provisions of the *EAS Act*. To date, the Commission have published five reports on VE/AS; however, examination of the reports was not possible as they are only produced in French.[37] Furthermore, it was not

[34] See *EAS Act* art 2(2)(2).
[35] 25 Questions, 25 Réponses on VE (n 5) 26.
[36] Brenton (n 33); 'Slight Rise in Euthanasia Cases in Luxembourg', *Luxembourg Herald* (Online, 30 May 2017) <http://luxherald.com/3054-slight-rise-euthanasia-cases-luxembourg.html>; Owen Dyer, Caroline White and Aser Garcia Rada, 'Assisted Dying: Law and Practice Around the World' (2015) 351 *British Medical Journal* 4481; Claudia Grosse and Alexandra Grose, 'Assisted Suicide: Models of Legal Regulation in Selected European Countries and the Case Law of the European Court of Human Rights' (2015) 55(4) *Medicine, Science and the Law* 246; Nicole Steck et al, 'Euthanasia and Assisted Suicide in Selected European Countries and US States' (2013) 51(10) *Medical Care* 938.
[37] Commission nationale de Controle at d'Evaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide, *Premier Rapport a l'attention de la Chambre des Deputes (Annees 2009 et 2010)* (Web Page, 2011) <https://sante.public.lu/fr/publications/r/rapport-loi-soins-palliatifs-2009-2010/rapport-loi-soins-palliatifs-2009-2010.pdf>; Commission nationale de Controle at d'Evaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide, *Deuxieme Rapport a l'attention de la Chambre des Deputes (Annees 2011 et 2012)* (Web Page, 13 Mars 2013) <https://sante.public.lu/fr/publications/r/rapport-loi-euthanasie-2011-2012/index.html>; Commission

possible to locate detailed discussion on this point in the peer-reviewed scholarly literature.[38] Thus, it remains to be seen how 'voluntary and does not result from external pressure' has been interpreted by the Commission or whether there are any rudimentary elements that form the basis of this examination. At the time of writing, no cases have been referred to the Public Prosecutor or Medical Council for investigation.[39] Thus, due to the absence of information in both primary and secondary sources of law, it is not possible to engage in further insight into how these substantive criteria are interpreted.

Summary

[13.40] As can be seen from this overview of practice and procedure of VE/AS in Luxembourg, voluntariness and absence from external pressure are key statutory safeguards under the law. It is the obligation of the euthanising physician to assess these criteria and failure to do so can result in criminal prosecution and/or professional disciplinary proceedings. To date, no referrals to either body have been made. And although protection of a voluntary decision is a substantive safeguard, these key terms are not defined under the law, and, as discussed in [13.30], information regarding how these criteria have been interpreted and applied is non-existent. Thus, consistent with other jurisdictions, there is minimal discussion concerning how these protections operate

nationale de Controle at d'Evaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide, *Troisieme Rapport a l'attention de la Chambre des Deputes (Annees 2013 et 2014)* (Web Page, April 2015) <https://sante.public.lu/fr/publications/r/rapport-loi-euthanasie-2013-2014/index.html>; Commission nationale de Controle at d'Evaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide, *Quatrieme Rapport a l'attention de la Chambre des Deputes (Annees 2015 et 2016)* (Web Page, June 2017) <https://sante.public.lu/fr/publications/r/rapport-loi-euthanasie-2015-2016/index.html>; Commission nationale de Controle at d'Evaluation de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide, *Cinqueme Rapport a l'attention de la Chambre des Deputes (Annees 2017 et 2018)* (Web Page, 2019) <https://sante.public.lu/fr/publications/r/rapport-loi-euthanasie-2017-2018/index.html >.

[38] Brenton (n 33); 'Slight Rise in Euthanasia Cases in Luxembourg', *Luxembourg Herald* (online, 30 May 2017) < http://luxherald.com/3054-slight-rise-euthanasia-cases-luxembourg.html>; Dyer, White and Rada (n 36); Grosse and Grose (n 36); Steck et al (n 36). Lopez remarks that Luxembourg remains overlooked in the existing scholarly literature due to the small number of reported cases of VE/AS: see Gina Lopez, *Dying with Dignity: A Legal Approach to Assisted Death* (Praeger, Santa Barbara California, 2015) 171–73; see also Julia Nicol and Marlisa Tiedemann, 'Euthanasia and Assisted Suicide: The Law in Selected Countries' (Publication No. 2015-116-E, Library of Parliament, Canada, 2015) 17.

[39] Brenton (n 33); Nicol and Tiedemann (n 38) 17.

in Luxembourg, and it remains to be seen whether these pivotal protections actually meet the objective of safeguarding against unacceptable forms of external pressure. The reason(s) behind adopting this position, whatever they may be, do not justify the end. Greater transparency concerning the protections adopted to safeguard a voluntary decision should be articulated in a more open way because of the gravity of the subject matter – death is final.

Chapter 14: Safeguarding a voluntary decision — different means to achieve the same desired end

Introduction

[14.10] It was observed in the opening chapter of this Part that a shared characteristic of all VAD legislation was the broad recognition of the need to protect a voluntary request. The aim of Part 2 was to navigate the murky (legal) waters on this specific aspect of VAD law, outlining the response to safeguarding a voluntary request in each jurisdiction. In undertaking this comparative legal analysis, it was found that a key element of a valid request was that it must be made voluntarily. The medical practitioner to whom the initial request for VAD is made must, if they do not conscientiously object, ensure that the person is, at a minimum, acting voluntarily. Heavy penalties can apply if this obligation is not appropriately discharged, although, to date, the evidence indicates that no medical practitioner has been prosecuted for failing to comply with this specific legal obligation in any of the jurisdictions considered. Whilst this foundational safeguard is agreed upon, notable differences exist amongst the jurisdictions concerning the language utilised and procedure mandated to achieve this desired end.

This closing chapter of Part 2 will bring together the common themes and points of difference between these jurisdictions. Perceived limitations with the statutory response to safeguarding a voluntary decision in general will be highlighted, although this discussion will be brief. The primary focus of this chapter is the legislative response to safeguarding against undue influence. Identifying and clarifying the issues with undue influence in this chapter serves as an important precursor to the discussion provided in Part 3, where a critical examination of the doctrine of undue influence as a safeguard for a voluntary request for VAD will be undertaken, considering whether it provides

meaningful protection of a voluntary decision or merely exposes the patient unacceptable risk.

Medical practitioner's duty to safeguard a voluntary request

[14.20] In all jurisdictions, it is the obligation of the medical practitioner who receives the request for VAD to determine that the patient is making the request voluntarily. However, assessment of the voluntary nature of the request is not undertaken in isolation, and, in most jurisdictions, this is supplemented by a requirement to examine for behaviour that serves to vitiate voluntariness. For example, in Victoria and Western Australia, the obligation is to ensure that the patient is 'acting voluntarily and without coercion'.[1] In Belgium, Luxembourg and Canada, the medical practitioner is obliged to ensure that the request is voluntary and not the result of external pressure.[2] The language in the province of Quebec differs slightly, replacing 'voluntary' with 'freely made', but still requiring the medical practitioner to examine for elements of external pressure.

The position in the US jurisdictions requires the medical practitioner to ensure that the person is acting voluntarily. However, California, Colorado and Maine require the medical practitioner to ensure that the request does not arise from coercion or undue influence. In the Netherlands, however, the *Review Procedures Act* refrains from complementing the obligation to examine voluntariness with an additional term. The extraneous material that interprets the scope of this criterion, defines voluntary as consisting of two separate elements, one being that it must be 'externally voluntary' — that is, free from external

[1] *Voluntary Assisted Dying Act 2017* (Vic) s 20(1)(c) ('*VAD Act* (Vic)'); *Voluntary Assisted Dying Act 2019* (WA) s 16(1)(e) ('*VAD Act* (WA)').
[2] See Table 6.

pressure, whilst the other element — 'internal voluntariness' — focusses on questions of capacity to consent.[3]

In addition to this initial assessment of voluntariness, the majority of jurisdictions require the voluntariness of a request to be medically confirmed. For instance, a confirming medical opinion on the voluntary nature of the request is required in Victoria, Western Australia, Canada, the Netherlands, and the US jurisdictions. In Belgium, this requirement only arises when the person's death is not imminent. In Luxembourg and the Province of Quebec, there is no requirement for voluntariness to be medically confirmed, as medical confirmation is limited to diagnosis and prognosis of the medical condition.[4] The exclusion of this obligation in the respective legislation does not necessarily mean that medical confirmation of voluntariness cannot be sought; it simply translates to there being no explicit mention of this in the law itself.

Western Australia and Victoria have gone further than other jurisdictions and require referral to a third specialist if either medical practitioner is suspect of the volition of the request, meaning that this provision is engaged only if there is residual doubt on this point. This added precaution is similar to the position adopted in several past VAD bills in South Australia, which required medical practitioners to refer the patient to another specialist if they suspected the person's volition was undermined.[5] Whilst the majority of jurisdictions require voluntariness to be assessed twice, the protective position in Victoria and Western Australia are heightened, with several additional assessments of voluntariness required right up until the point of administration, all of which are outlined

[3] See Table 8 for an overview of the terms used.
[4] *Act Respecting End of Life Care* (Quebec) s 29(3); *Belgian Act on Euthanasia of May, 28 2002*, Art 3 § 3(1), cited in Dale Kidd, '*The Belgian Act of Euthanasia of May, 28th 2012*' (2003) 10 *European Journal of Health Law* 329.
[5] See Table 5 for an overview of these criteria in past South Australian bills.

in Table 6. Western Australia has, however, gone one step further than Victoria in their approach to safeguarding a voluntary request.

The *VAD Act* (WA) permits eligible applicants to apply to the State Administrative Tribunal (WA) (the 'Tribunal') for review of a medical practitioner's decision regarding whether the person was acting voluntarily and without coercion prior to VAD being authorised.[6] The power to review is not unlimited and applies to three defined stages of the consent process where assessment of acting voluntarily and without coercion is performed. These stages are the

1. coordinating medical practitioner's first assessment of the patient;[7]
2. consulting medical practitioner's assessment of the patient;[8] and
3. coordinating medical practitioner's statement in a final review form certifying volition.[9]

It is interesting to note that both positive and negative findings concerning volition can be challenged before the Tribunal,[10] thus granting the Tribunal broad jurisdiction over issues concerning volition, with the power to deem a person either eligible or ineligible to access VAD.[11] This increased emphasis placed on protecting a voluntary request in Western Australia is unique as no other jurisdiction has such a prescriptive approach to safeguarding a voluntary request. Furthermore, the position adopted in Western Australia is unique as it recognises that pressuring someone *not* to request to VAD can

[6] See s 84; see also *VAD Act* (WA) s 83 (definition of 'eligible applicant' paras (a)–(c)).
[7] *VAD Act* (WA) s 84(1)(a)(iii); see also ss 16(1)(e), 24(2). The co-ordinating practitioner is defined as a medical practitioner who accepts the person's first request for VAD or who accepts transfer of the role of co-ordinating practitioner under s 157, and is responsible for administering the VAD substance: see s 5 (definition of 'co-ordinating practitioner' (paras (a), (b)) and definition of 'administering practitioner' (paras (a), (b)).
[8] Ibid s 84(1)(b)(iii); see also ibid ss 16(1)(e), 35(2). Consulting practitioner is defined as 'a medical practitioner who accepts a referral to conduct a consulting assessment of the patient': see ibid s 5 (definition of 'consulting practitioner').
[9] Ibid s 84(1)(c)(ii); see also ibid s 52(3)(f)(ii).
[10] Ibid ss 84(1)(a)(iii), 84(1)(b)(iii) and 84(1)c)(ii).
[11] See ibid ss 88(e), 88(f), 90.

also amount to an affront to their autonomy. The *VAD Act* (WA) just commenced operation on 1 July 2021, and, to date, there are no discussions on Tribunal findings. However, it will be intriguing to watch this space and whether questions concerning voluntariness are raised at a tribunal level.

It can, therefore, be concluded from this comparative legal analysis of VAD legislation that there are significant variations between the jurisdictions concerning the role of medical practitioners in safeguarding the voluntariness of a request. All jurisdictions have recognised that this is a fundamental criterion to satisfy in order to be eligible to access VAD. The measures taken to protect this vary slightly and several jurisdictions have taken the additional step of calling upon witnesses as added insurance of a voluntary request.

Witness's duty to safeguard a voluntary request

[14.30] The requirement for witnesses to certify the voluntariness of a request for VAD was not a consistent feature of VAD legislation, with Victoria and Western Australia and the US jurisdictions favouring this approach. As outlined in Table 6, in the US jurisdictions, the witness provisions were largely consistent, with each jurisdiction defining the requirements of a valid request for PAD. For instance, a core requirement of a request was that it be attested to by two witnesses who must confirm that the person was acting voluntarily and not being coerced to sign the request.[12] The corresponding obligation placed on witnesses is to declare on the person's written request for PAD that they did not appear to be under duress or *undue influence*,[13] thus rendering witnesses as arbiters

[12] Slight differences are evident in New Jersey, Vermont and Washington DC concerning the terms used in the requirements for a valid request: see Table 6 for clarification.
[13] Colorado went further by also requiring witnesses to declare that the person does not appear to acting under coercion: see Table 6.

on questions of undue influence. There is, however, a notable language discrepancy in the valid request provisions and witness declaration provisions that warrants brief consideration.[14]

As noted in **[14.20]**, two separate provisions discuss the role of witnesses. The first provision addresses the requirements of a valid request and what witnesses must attest to; the second establishes what witnesses must declare on the written request for PAD. For instance, under §2.02(1) of the *DDA* (Oregon), a valid request for medication must be witnessed by two witnesses who attest, to the best of their knowledge and belief, that the person is *acting voluntarily* and *is not being coerced* to sign the request.[15] However, under §6.01, two witnesses must declare that the person signing the request is not under *duress* or *undue influence*.[16] Therefore, the issue is that, under §2.02,[17] the terms used are *voluntary* and *coerced*; however, under §6.01,[18] the terms used are *duress* and *undue influence*. This linguistic discrepancy is evident in Washington, Maine, Hawaii, Washington DC, Colorado and New Jersey. However, no such discrepancy exists in California or Vermont as the language used in the valid request provisions and witness declaration provisions is consistent. The pivotal terms underlined above have not been defined in any of the legislative instruments, and the courts have not yet been called upon to determine definitions. Therefore, it is not possible to reconcile this inconsistency in language and it remains equivocal to say the least. It is apparent that witnesses carry a heavy burden, as they are required to safeguard against a variety of different behaviours,

[14] This is not the case for California and Vermont as the language is consistent in both provisions. See Table 7 for a comparative overview of the different terms.
[15] *DDA* (Oregon) §2.02(1) (own emphasis).
[16] Ibid §6.01 (own emphasis).
[17] Ibid.
[18] Ibid.

including undue influence, none of which have been defined.[19] A similar approach is also adopted here in Australia, although these linguistic incongruities have been avoided.

In Victoria and Western Australia, witnesses are called upon to safeguard the voluntariness of a request for VAD. The obligation of witnesses in Victoria and Western Australia differs from the US jurisdictions, as they employ consistent and potentially more straightforward language. In Victoria and Western Australia, two eligible witnesses are required to certify that the person making the written declaration for VAD appeared to be acting freely and voluntarily. However, in cases of practitioner administration of the VAD substance, the obligation of witnesses continues. The *VAD Act* (Vic)[20] requires that the patient's request for administration must be made in the presence of an eligible witness who must declare, on the appropriate form, that the person requesting administration appeared to be acting voluntarily and without coercion.[21] In Western Australia, a similar position has been implemented. Under the *VAD Act* (WA), a witness must also declare that the person requesting administration of the VAD substance appeared to be free and voluntary.[22] Therefore, similar to the US jurisdictions, witnesses in Victoria and Western Australia have the added responsibility of safeguarding a voluntary request for VAD. However, unlike the US jurisdictions, the use of technical legal language such as undue influence to serve as a safeguard has been omitted.

What themes emerge from the comparative analysis?

[19] The obligation placed on witnesses potentially places a heavy burden on them, one that cannot be possibly truly understood by them. This is considered in detail in Chapter 16.
[20] Schedule 1, Form 3.
[21] Section 65(2)(a)(ii).
[22] Section 62(3)(a). There is a slight difference regarding the requirements for witnessing the administration of VAD in Victoria and Western Australia: see *VAD Act* (Vic) ss 64(4), 65(2)(a)(ii); cf *VAD Act* (WA) s 62(3)(a).

[14.40] It is evident that there is a consistency among all jurisdictions to provide broad protection of a voluntary decision to request VAD. The approach is, however, varied across the jurisdictions. Despite these differences, the common theme that arises is that there is a failure to define key terminology which can undermine meaningful protection of this pivotal safeguard.

Failure to define terminology

[14.50] Protection of a voluntary decision against some form of external pressure is a fundamental safeguard and core requirement of a valid request. This is recognised across all of the jurisdictions considered here, yet there is an absence of clarity regarding the key terms. For ease of reference, these terms have been reproduced in Table 8 below. The sources relied upon to undertake this comparative analysis were primary and secondary sources of law, and included examination of legislation, regulations/delegated legislation, court and tribunal decisions, and review bodies authorised to interpret the law. Parliamentary materials — parliamentary debates (*Hansard*), explanatory memoranda and parliamentary committee reports — were also considered, as well as scholarly material. Upon review of the available information, no definition of the key terms utilised in the respective legislative instruments could be located. This was consistent in all jurisdictions. The only exception is that the Regional Review Committee in the Netherlands provided some discussion on the external voluntariness due care criterion yet stopped short of providing important insight into this element of law. Furthermore, there was no evidence to suggest that a medical practitioner has been sanctioned for failing to comply with this specific aspect of the law; therefore, there is no judicial consideration on this point. A notable point of distinction, however, is that the US jurisdictions response to safeguarding a voluntary request is comparatively extravagant

to the other jurisdictions considered, although they too have not imputed meaning into their statutory protections.

The US jurisdictions have introduced a suite of safeguards including protection against coercion, duress and undue influence. However, no definition, discussion or guidance is provided to witnesses and medical practitioners (where relevant) called upon to undertake this assessment. Thus, it is unclear whether witnesses or medical practitioners understand the nuances between these terms or what is being asked of them. It is clear that the protection against behaviour that would undermine a voluntary decision was intended to be broad, yet, if the individuals called upon to make this assessment do not understand the scope of protection offered by undue influence, vis-à-vis, duress, then the protective position of the law is significantly weakened. Furthermore, whilst there exists some discussion in the scholarly literature on the use of undue influence in the area of conservatorship of estate applications in California,[23] this has been overlooked in the area of PAD which is a concerning oversight given the gravity of PAD. It is unclear why the key terms utilised to safeguard a voluntary request have not been defined, not only in the US jurisdictions but all jurisdictions considered in Part 2. When looking at other aspects of VAD legislation, some jurisdictions have carefully articulated important conditions that must be met in order to access VAD. For instance, the legislative response regarding capacity to consent to VAD has been subject to careful consideration in most jurisdictions.[24] The importance of ensuring that the individual requesting VAD has decision-making capacity cannot be overstated and is not challenged. It is fundamental, as failure to ensure decisional capacity is also an affront to voluntariness and individual

[23] See Mary Joy Quinn et al, 'Developing an Undue Influence Screening Tool for Adult Protective Services' (2017) 29(2)–(3) *Journal of Elder Abuse and Neglect* 157.
[24] See, eg, *VAD Act* (Vic) s 4; *VAD Act* (WA) s 6(2); *DDA* (Oregon) §1.01(3) (definition of 'capable').

autonomy. But so too is failing to ensure that the request has been made voluntarily. Both voluntariness and capacity are important safeguards that serve to uphold autonomy, although they focus of different aspects of the decision-making process.[25] However, capacity on the one hand has been carefully defined, whilst the voluntariness safeguards have been profoundly overlooked.

It is understandable why capacity has been carefully defined. A consequence of not ensuring that capacity has been clearly determined is dangerous, as it is traversing into the territory of non-voluntary euthanasia, which is clearly undesirable. Clear steps must be taken to ensure that decision-making capacity is verified. However, failing to meaningfully safeguard a voluntary decision is equally egregious. It remains to be seen why there is an absence of clarity concerning the terminology that serves to protect a voluntary decision and divergent theories can be inferred from this position of silence.

Potential reasons for this omission is that defining these terms is prescriptive and burdensome or perceived by medical practitioners as too regulatory, an example of the law unnecessarily encroaching on medical practice. The preferable approach is to leave questions of voluntariness open to interpretation within the context of the consultation, to be strictly determined by the medical practitioner, thus giving medical practitioners

[25] Some scholars have argued that, in the context of requesting VAD, assessment of undue influence should form part of a capacity assessment: see Cameron Stewart, Carmelle Peisah and B Draper, 'A Test for Mental Capacity to Request Assisted Suicide' (2011) 37(1) *Journal of Medical Ethics* 34; Carmelle Pesiah, Linda Sheahan and Ben White, 'Biggest Decision of them all — Death and Assisted Dying: Capacity Assessments and Undue Influence Screening' (2019) 49(6) *Internal Medicine Journal* 792. Whilst this position is not outright rejected, it does not resolve the issues that arise with the use of undue influence as a safeguard in the context of VAD. Whether screening for undue influence is undertaken as part of a capacity assessment or independent of it, under the scope of the voluntary safeguards, undue influence must be clarified and articulated for it to be a meaningful safeguard. Furthermore, Pesiah, Sheahan and White contend that screening for undue influence under the *VAD Act* (Vic) should be performed within the scope of a capacity assessment. The *VAD Act* (Vic) itself is silent on screening for undue influence, it is not included a safeguard under the Act, although the *VAD Act* (Vic) explicitly states that approved training for medical practitioners should focus on 'identifying and assessing risk factors for abuse or coercion': see s 114(c). Conflating capacity assessments and screening of undue influence, although the authors correctly note that they are separate principles, does little clarify what undue influence is and is likely to lead to further confusion.

latitude to determine this question. Additionally, this position is likely to facilitate the review procedure process, as assessing whether the medical practitioner properly assessed voluntariness is inherently difficult to independently verify, especially as compliance review is performed retrospectively and based on examination of self-reported forms.

If this line of reasoning is adopted, then this argument is more defensible in the Netherlands, Belgium, Luxembourg, Canada, the Province of Quebec, and, to some extent, Victoria and Western Australia. The generality of the terms used in these jurisdictions supports this conclusion. However, this argument is difficult to sustain in the US jurisdictions. The position in most of the US jurisdictions only requires medical practitioners to determine/verify that the person was acting voluntarily — a seemingly straightforward term. However, in California, Colorado and Maine, the attending medical practitioner is explicitly required to examine for coercion and undue influence in a request for PAD. Therefore, in these three jurisdictions, the process is complicated by the inclusion of technical language, thus requiring the medical practitioner to turn their mind to specific forms of behaviour. Furthermore, the obligation placed on witnesses to declare that the person appeared to be acting free from duress or undue influence is further evidence of the use of technical language, and a significant shift from straightforward terminology. Thus, it begs the question of whether these additional terms, in the absence of clarity or guidance, actually provide any meaningful protection of a voluntary decision.

However, regardless of what terminology is utilised — straightforward or technical — surely clarity and guidance is preferable to silence. Whether the respective legislatures choose to provide a legislative definition of their chosen terms, or regulate this through the passing of delegated legislation or regulations, clarifying the safeguards that aim to

protect a voluntary request do not have to be overly prescriptive or encroach on the medical practitioner's ability to exercise professional judgment. It may succeed in establishing clearer parameters concerning unacceptable behaviour that would raise a red flag, indicating that voluntariness is potentially being undermined by undue influence, coercion, duress or external pressure. Furthermore, in the US jurisdictions, defining and distinguishing between undue influence, duress and coercion may result in a robust examination by witnesses and, where relevant, medical practitioners. Whilst this is one potential explanation for this collective ambiguity, an alternative argument is that this sustained silence is perhaps indicative of a bigger issue: that voluntariness and the corresponding behaviours that seek to undermine it — undue influence — are an inherently difficult thing to independently identify.

Assessment of voluntariness looks beyond the individual, their illness (diagnosis and prognosis) and questions of capacity, and requires examination of the patient's external environment for behaviour that would vitiate a voluntary request. It is not a question that has a firm basis in medical science. It is unlikely to be as obvious as a malignant tumour in an MRI or neurological degeneration caused by amyotrophic lateral sclerosis. It is not readily quantifiable. In many instances external pressure, undue influence, duress or coercion are unlikely to be overt and easily identifiable. If someone in the patient's external environment is acting with sinister intentions, then this will be covert, prolonged and occur behind closed doors. Furthermore, the individual subject of the coercion, external pressure or undue influence may not actually be aware that it is happening. Because of the inherent difficulty in examining something intangible, it is preferable to omit discussion of it. Consideration of the review procedure operational in each jurisdiction was examined as part of the comparative analysis in Part 2. It was observed that, in nearly all jurisdictions, there was no discussion on voluntariness or any of the

supplementary safeguards. There is very little discussion on whether concerns were raised regarding volition, or how medical practitioners and witnesses, where relevant, determined that a request was voluntary and what factors they took into account when undertaking this examination.[26] Minimal adverse information concerning voluntariness has been reported.

Another potential reason may be that, despite the lack of clear legislative guidance and regulation, medical practitioners are able to properly examine that the person is acting voluntarily and not under undue influence or external pressure. So too are witnesses, as there is no evidence to suggest that witnesses have raised concerns with undue influence or duress. Therefore, in the context of VAD, this is not a concern. However, an alternative argument is that voluntariness and undue influence are so difficult to identify and independently verify that it is better to overlook discussion on these altogether, otherwise risk exposing gaps in the legislative response to safeguarding a voluntary request. The position taken here aligns with the latter proposition — that the silence is likely indicative of a bigger issue. However, without such legislative protections, it is unlikely that any VAD law would be enacted, as appearing to have a strong system of statutory safeguards to protect a voluntary decision is necessary to ensure that VAD law receives strong public (and parliamentary) support; therefore, these protections likely exist to placate both supporters and opponents of VAD alike. Legalising VAD is controversial and not accepted uncritically. In an attempt to allay concerns, the legislative response strives to balance competing interests, including the need to provide individuals the choice to request VAD and the need to ensure that that choice is exercised voluntarily. To satisfy the latter

[26] It is necessary to mention that there is significant variation between the jurisdictions concerning what information is released in the annual or biennial reports. For example, cf the US jurisdictions discussed in Chapter 9 and the Netherlands considered in Chapter 11. Regardless of the style of the report, in order to provide a convincing picture regarding how VAD is working, a concerted effort should be made to communicate this information.

requirement, statutory safeguards were introduced to meet this end. Prima facie examination of any of VAD statutes indicates that voluntariness is protected. In most jurisdictions, two medical practitioners are required to determine voluntariness, and in the US jurisdictions and in Victoria and Western Australia, witnesses are also obliged to protect this vital principle. Furthermore, the suite of protections incorporated in the US jurisdictions does paint a convincing picture that strong safeguards have been put in place to ensure that voluntariness is being protected. However, what remains to be seen is whether this is actually occurring in practice. Of the information on VAD that is made public by the respective review bodies, this element of the law is very rarely discussed and the data on this point is usually presented in a positive light. It is acknowledged that other arguments can be proffered to explain this position. However, examination of them is beyond the narrow scope of this project. Regardless of the underlying reasons for failing to define the key terminology, it is likely that clarity and guidance is likely to lead to a more robust examination and provide meaningful protection of a voluntary decision. The overarching obligation *must* be protection of the patient.

The foregoing discussion was intentionally broad in scope, considering the response to safeguarding a voluntary decision in general, to emphasise the consistent focus on safeguarding a voluntary decision alongside the equally consistent failure to define key terms. It is now necessary to limit this discussion to examination of undue influence. Consideration of the broader response to safeguarding a voluntary request was important to this narrative as undue influence certainly falls under this class of protections. However, they will not be discussed moving forward and undue influence will now be the focus of this discussion.

The issue with undue influence

[14.60] Concerns with the use of undue influence as a statutory safeguard have been alluded to throughout Parts 1 and 2 of this thesis. Part 1, Chapter 5, discussed the response to safeguarding against undue influence in South Australia, where six different VAD bills tabled in parliament included this as a safeguard;[27] Chapter 9 examined the response to safeguarding against undue influence in the US jurisdictions. It was observed that there are striking similarities with the response to safeguarding against undue influence in the US jurisdictions and several past South Australian VAD bills. Due to these similarities, it can be inferred that the South Australian legislature were likely influenced by the position in the US jurisdictions on this aspect of the law. It is not unusual for jurisdictions considering legalisation to turn to other jurisdictions for inspiration and guidance. One notable difference was that the position proposed in South Australia was more onerous, as medical practitioners in the selected South Australian bills were required to screen for undue influence, whereas only three states in the US jurisdictions adopted this position.[28] A remarkable shared feature was that the legislation in the US jurisdictions and the South Australian bills did not define or clarify what is undue influence. It was presented in a way that overlooked the historical legal roots of the doctrine and appeared to assume an ordinary meaning, which is an erroneous position to take. Furthermore, upon critical examination of undue influence in the US jurisdictions, it cannot be concluded that undue influence is working well as a safeguard. Of the data that has been released in the annual or biennial reports in the US jurisdictions, there is no discussion of undue influence. It is unclear whether steps have been taken to explain or educate medical practitioners and witnesses on what it is, what it serves to protect and,

[27] See Table 5 for an overview of these bills.
[28] See Table 5 and Table 6 for an overview of the response to safeguarding against undue influence.

how it should be examined.[29] Thus, there is an absence of convincing evidence to indicate that protection against undue influence is working well in practice. The issue this presents for South Australia is that VAD legislation has been passed, and the legislature is now focussing on implementing the law. Given South Australia's previous reliance on the US jurisdictions' response to safeguarding against undue influence, it is possible that undue influence, although omitted as a statutory protection, will be adopted as a safeguard in a regulatory instrument authorised under the law,[30] without critical examination of how this will work in practice. The issue here is how will it translate from a theoretical safeguard to a concrete one? Use of undue influence as a statutory safeguard should be reconsidered as there is a strong argument that, without further guidance or explication, it is unlikely to provide meaningful protection of a voluntary decision, instead exposing parties to unacceptable risk. The following Part will provide a critical analysis of the doctrine of undue influence, defending why it is inappropriate as a statutory safeguard.

Where to now?

[14.70] The statutory landscape concerning protection against undue influence (and protection of voluntary choice in general) has clearly been established. This was the primary focus of Parts 1 and 2. The next step is to critically examine the doctrine of undue influence itself. The position adopted here is that undue influence is a legal term and, in

[29] It is necessary to note that recent developments have occurred in the USA to inform and educate physicians and others involved in PAD. In response to the increasing popularity of PAD legislation in the USA, the American Clinicians Academy on Medical Aid in Dying (the 'Academy') was established on 15 February 2020: see 'Introduction to the Academy', *American Clinicians Academy on Medical Aid in Dying* (Web Page, 2021) <https://www.acamaid.org/>. The impetus behind establishing the Academy was the increasing availability of PAD in the USA and the lack of a formal, far-reaching training body as a source of education and referral for physicians and others involved in PAD. Whilst the mandate of the Academy is broad, they have established certified continuing medical education for physicians providing PAD and offer 'expert consultations for clinicians facing complex bedside decisions about medical aid in dying' see 'Introduction to the Academy', *American Clinicians Academy on Medical Aid in Dying* (Web Page, 2021) < https://www.acamaid.org/>.

[30] *Voluntary Assisted Dying Act 2021* (SA) s 130.

its proposed form as a statutory safeguard in South Australia, is not apt for use outside of the legal realm. The historical equitable origin of undue influence, and its subsequent expansion into other areas of law, is an important part of this narrative and it is necessary to articulate how undue influence operates in the current legal system. Once this has been established, only then can it be understood why it is inappropriate as a statutory safeguard in the area of VAD. Chapter 15 will focus on undue influence and its application in equity and law. Chapter 16 will specifically address the issues that may arise as a consequence of uncritical reliance on undue influence as a statutory protection. Chapter 17 turns to a consideration of risk that reliance on undue influence is likely to pose to patients and medical practitioners. Chapter 18, the final chapter, will provide concluding thoughts, recommending steps that can be taken to mitigate the concerns raised, and considering how vulnerable patients can be afforded meaningful protection of a voluntary decision.

Table 8 – Overview of Key Legislative Terms

Jurisdiction	Voluntary	Freely	Coercion	Duress	Undue Influence	External Pressure
Australia						
Victoria	✓	✓	✓			
Western Australia	✓	✓	✓			
North America						
Canada	✓					✓
Quebec, Canada		✓				✓
California, USA	✓		✓	✓	✓	
Colorado, USA	✓		✓	✓	✓	
District of Columbia, USA	✓			✓	✓	
Hawaii, USA	✓		✓	✓	✓	
Maine, USA	✓		✓	✓	✓	
New Jersey, USA	✓			✓	✓	
Oregon, USA	✓		✓	✓	✓	
Vermont, USA	✓			✓	✓	
Washington, USA	✓		✓	✓	✓	
Europe						
The Netherlands	✓					✓[31]
Belgium	✓					✓
Luxembourg	✓					✓

[31] This is not explicit in the *Review Procedures Act* itself. See Chapter 11 for further discussion.

No Court has ever attempted to define undue influence. One reason for the difficulty in defining undue influence is that the label "undue influence" has been used to mean different things.[1]

[1] *Thorne v Kennedy* (2017) 350 ALR 1, 10 (Keifel CJ, Bell, Gageler, Keane and Edelman JJ).

Introduction

[15.10] The position adopted throughout this thesis is that undue influence primarily exists as a legal term. It is not a term that has a firm basis in the common English lexicon and, therefore, does not have an 'ordinary meaning' outside of the law. As a consequence of its historical legal origin, issues arise regarding the suitability of undue influence as a proposed safeguard for a voluntary request for VAD. The use of the phrase 'undue influence' in any Australian VAD legislation is therefore contentious. If the legal meaning is intended, then questions must be asked as to whether it is suitable as the proposed safeguard for a voluntary request for VAD. If another meaning is intended, then greater clarity from the legislative provisions will be necessary to avoid the implication that the legal meaning, discussed in the chapters to follow, is relevant.

Parts 1 and 2 of this thesis were concerned with establishing the statutory landscape of safeguarding a voluntary request for VAD. Part 1 considered VAD law reform from a uniquely South Australian perspective, focusing on how the South Australian legislature proposed to safeguard a voluntary decision against external pressure, which eventually saw the introduction of screening for undue influence as part of the legislative suite of protections. Part 2, on the other hand, provided a comparative analysis of VAD legislation, discussing the response to safeguarding a voluntary request operational in other jurisdictions. It was necessary to widen the focus of Part 2 and broadly consider the legal response to safeguarding a voluntary request in general, as whilst there was a broad consensus that a request for VAD needed to be protected against some form of third-party pressure, the terminology used to meet this end differed. The nexus between undue influence and voluntariness is that undue influence undermines a voluntary decision and

serves as grounds to have a decision set aside. In the context of VAD, screening for undue influence fits under the class of protections that aim to safeguard voluntary choice. Whilst the approach to VAD differs across jurisdictions, the protection of voluntary choice is consistently given priority. The manner in which this is achieved varies across jurisdictions, however, and it was important that a broad discussion of these safeguards, providing crucial context for the South Australian focus on undue influence. Whilst this comparative legal analysis highlighted some significant differences, it also drew into sharp relief some striking similarities regarding screening for undue influence between the legislation in force in the US jurisdictions and several past South Australian VAD bills.

In Part 3, the focus now turns to a critical analysis of the doctrine of undue influence and this will begin with a broad consideration of the nature of the doctrine. This discussion will demonstrate that undue influence as a safeguard in this novel context is a blunt instrument. Whilst it is clear that the motivation for adopting stringent safeguards to protect persons from being inappropriately influenced into requesting or accessing VAD is important, and indeed justified, the contentious issue resides in the fact that this is a complex legal doctrine. Reliance on opaque technical legal terms in this context should be avoided, as it is unlikely to enhance protection of a voluntary decision, contrary to the purpose of the law. Part 3, therefore, stands as a critical examination of the doctrine of undue influence and asserts that its adoption as a proposed statutory safeguard without explication or guidance is problematic, fails to provide meaningful protection of a voluntary decision, and serves to expose those parties called upon to screen for undue influence to unacceptable risk.

This final Part will be divided into four chapters. The focus of the present chapter is to provide a critique of the doctrine of undue influence. This discussion will first consider its

historical roots in equity (being the equitable origin of undue influence), followed by an examination of its subsequent expansion into other areas of law. The purpose of this chapter is twofold. First, it seeks to describe what undue influence is, identifying its nature, and highlighting what it aims to protect. As will be discussed, undue influence has evolved as a doctrine, with each application of the doctrine modifying the elements. However, despite this evolution, some basic tenets of undue influence are consistent. Second, this chapter serves to demonstrate that, although the underlying nature of undue influence is consistent, its application is far from straightforward. From a legal standpoint, what undue influence means depends upon what area of law applies, which requires examination of the facts in a case. This chapter will discuss undue influence in equity, probate, and medical law. This will serve to clearly articulate its complexity in both equity and law, setting the scene for the discussion that follows on undue influence as a safeguard in proposed VAD legislation. Chapter 16 will consider two issues that are likely to arise due to reliance on undue influence as a proposed statutory safeguard in VAD legislation. It will first reveal that, as a consequence of its history and variation in its application, undue influence is a doctrine that is fact dependent and does not provide a precise definition. This will then lead to the second key point, which is that whilst undue influence has a firm basis in the law, it does not have an ordinary meaning. This then leads to the assertion that medical practitioners and the general public should not be required to be arbiters on questions of undue influence. Chapter 17 will highlight risks that the two issues identified in Chapter 16 present for the parties involved in the VAD process — the patient and the medical practitioner. Chapter 18 will draw together the preceding discussions and provide recommendations to mitigate the concerns identified

What does undue influence seek to protect? Undue influence in equity, probate and

consent to medical treatment

[15.20] We live in a time where the law prioritises the principle of individual autonomy and protects capable adults right to enter into transactions, execute a will, dispose of their property,[2] and refuse life-saving medical treatment, even if the outcome will cause significant harm to life and/or health.[3] However, for such decisions to be binding at law they must be voluntarily made — that is, they must be free from unacceptable external pressure.[4] Undue influence is a form of unacceptable external pressure. Although undue influence has been expressed in a variety of different ways, it was initially solely recognised by the jurisdiction of equity and is a ground to challenge the validity of a contract, transfer of property, gift, will, or consent to, or refusal of, medical treatment as the case may be. However, in these separate areas of law, undue influence has distinct meanings which have been shaped by the nature of the law, the interest being protected, and the surrounding judicial narrative. If, however, undue influence is to be introduced as a legislative safeguard of a voluntary decision, then the variance in its application must be addressed to appreciate the challenges that arise when it is relied on as a legislative safeguard of a voluntary request for VAD. Under existing law, no specific definition of undue influence exists and what version of undue influence is being applied depends on the issues in dispute. Therefore, important questions for consideration in VAD are, in the absence of clear legislative guidance, what does undue influence mean in the VAD context? Is it sufficiently clear in the legislation how screening for undue influence during the VAD

[2] See, eg, *Huguenin v Beasley* (1809) 14 Ves. Jun 273, 290 (Eldon LC); *Allcard v Skinner* (1887) 36 Ch. D., 182-83 (Lindley LJ) ('*Allcard*'); *Brusewicz v Brown* [1923] NZLR 1106, 1109. See also John Dawson, 'Economic Duress — An Essay in Perspective' (1947) 45 *Michigan Law Review* 253.
[3] See, eg, *Hunter New England Area Health Service v A* [2009] NSWSC 761 ('*Hunter*'). See also, *In re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam. 33, 44; *Malette v Shulman* (1990) 67 D.L.R. (4th) 321.
[4] Reference to the 'law' in this chapter means common law, equity and probate unless otherwise expressly indicated. These are the areas of law where undue influence is applied.

process will operate in practice?

Nature of the protection offered by undue influence

[15.30] The doctrine of undue influence was initially recognised by the Courts of Chancery in the early eighteenth century,[5] and later by the Probate Courts in the early part of the nineteenth century[6] and finally, in medical law cases in the late twentieth century.[7] In order to clearly articulate the nature of the protection offered by undue influence, and to understand its appeal as a statutory safeguard in the area of VAD law, it is necessary to first provide a general discussion of its historical origins in the jurisdiction of equity, addressing what injustices the doctrine of undue influence sought to remedy. Furthermore, it must be acknowledged that, despite its equitable origin, the subsequent expansion of undue influence to apply in other areas of law may have changed the shape of the doctrine, but the underlying nature of the protection remains consistent with the original doctrine. Without limiting its application to any one area of law, the general principle that undue influence aims to protect is the integrity of the decision-making

[5] See *Morris v Burroughs* (1737) 26 E.R. 253, [403] (Lord Hardwicke) ('*Morris*'); see also W H D Winder, 'Undue Influence and Coercion' (1939) 3(2) *Modern Law Review* 97; J Heydon, M Leeming and P Turner, '*Meagher, Gummow and Lehane's Equity: Doctrines and Remedies*' (LexisNexis Butterworths, 5th ed, 2015) [1-5-030].

[6] Winder argues that the term 'undue influence' was first applied to the probate line of cases in the early part of the nineteenth century: see Winder (n 4) 104-05. Here, he lists some of the early probate cases where the doctrine was applied: *Williams v Goude* (1828), 1 Hagg. Ecc. 577. 581; *Barry v Butlin* (1833), 2 Moo.P.C. 480, 484; *Baker v Batt* (1838), 2 Moo.P.C. 317, 329; *Boyse v Rossborough* (1857) 6 H.L. 2. For discussion on why the equitable doctrine transferred from Chancery to the law courts, see Carla Spivack, 'Why the Testamentary Doctrine of Undue Influence should be Abolished' (2010) 58 *University of Kansas Law Review* 245, 250.

[7] The first instance where undue influence was relied on as grounds to challenge the validity of a consent to medical treatment is difficult to pinpoint. However, it is thought that the earliest application of undue influence in this line of cases was in the UK, in the case of *re T (Adult: Refusal of Treatment)* [1993] Fam. 95. 111 ('*Re T*'). To support this view, reference to Lord Donaldson's MR judgment is necessary. His Lordship stated that the trial judge in *Re T* was 'faced with a situation which, in the context of an adult patient, is novel to the courts and had little or no guidance from the reported authorities'. In rejecting the trial judge's finding of fact, his Lordship continued, arguing: 'I think that there is abundant evidence which would have justified ... [the conclusion that] the influence of the mother was such as to vitiate the decision which she expressed.'

process, with a view to safeguarding voluntary choice against overbearing external influences that serve to undermine it.

What is equity?

[15.40] Historically, equity was administered by Courts of Chancery — a separate jurisdiction that has existed from around the thirteenth century in England.[8] A primary reason for the establishment of equity was to supplement the perceived harshness of common law causes of action and procedural rules. For instance, Heydon, Leeming and Turner remark that equity 'softened and modified many of the injustices in common law and provided remedies where at law they were either inadequate or non-existent'.[9] Therefore, one of equity's key functions was to provide an alternative to common law as it was not bound to the rigid principles that often plagued the common law, and this was often viewed as its great strength. For instance, when the application of the common law resulted in injustice or 'offended conscience', a party could bring an action before a court of equity to correct any wrong, as it was. This quote clearly articulates the focus of equity on 'conscience', which permits the jurisdiction to act flexible and responsively, but is also a significant cause of criticism

> Equity is according to the Conscience of him that is Chancellor, and as that is larger or narrower, so is Equity. 'Tis all one as if they should make the Standard for the measure we call a Foot, a Chancellor's Foot: what an uncertain Measure would be this? One Chancellor has a long Foot, another a short Foot, a Third an indifferent Foot: 'Tis the same thing in a Chancellor's Conscience.[10]

[8] For a historical discussion on the history of the Courts of Chancery, see generally Duncan Kerly, *An historical sketch of the equitable jurisdiction of the Court of Chancery* (Cambridge University Press, 1890); Alfred Henry Marsh, *History of the Court of Chancery and of the Rise and Development of the Doctrines of Equity* (Carswell & Co., 1890); Joseph Parkes, *A History of the Court of Chancery; With Practical Remarks on the Recent Commission, Report, and Evidence, and on the Means of Improving the Administration of Justice in the English Courts of Equity* (Longman Rees, 1828).
[9] Heydon, Leeming and Turner (n 4) [1-005]-[1-325]; see also Story, *Commentaries of Equity Jurisprudence* (Sweet and Maxwell Limited London, 3rd ed, 1920) 79-83.
[10] Henry Brown, 'Equity' (1914) 26(3) *Judicial Review* 338, 338, citing John Selden.

Therefore, the existence of the parallel jurisdictions of equity and common law often resulted in conflict, which eventually required the intervention of King James I in 1616, who decreed that equity reigned supreme over common law.[11] Maitland explains that the ideology behind equity being held superior to the common law was that it would stand in direct conflict to the maxims of Chancery about trust, conscience and remedying injustices 'if men were permitted to go to the common law courts and execute judgments obtained there'.[12] This principle survives today, expressed in several South Australian Acts.[13] A significant aim of equity in the past — to remedy unconscionable conduct and ameliorate the harshness of the common law — remains unchanged and the court's equitable jurisdiction is broad.[14] Despite this broad division, there are aspects of the two areas of law that inform each other. Duress and undue influence are two such areas, with duress being a common law cause of action and undue influence an equitable doctrine. Their relevance to this discussion is that protection against both undue influence and duress were required in several South Australian VAD bills,[15] as both operate to taint the decision-making process. Illustrating what each doctrine aims to protect and how they complement one another is important to understanding the nature of undue influence.

Equitable undue influence and common law duress: equity's response to bridge the gap left by common law duress

[11] See especially Dennis Klinck, '*Conscience, Equity and the Court of Chancery in Early Modern England*' (Ashgate Publishing Ltd, 2010); see also Heydon, Leeming and Turner (n 4) [1-005]-[1-325]; F W Maitland, *Equity: A Course of Lectures* (Cambridge University Press, 2nd ed, 1947) 9–11.
[12] Maitland (n 11) 9–11. It is necessary to note that an injunction issued by the Chancery against a judgment obtained by a common law court was not addressed to the judges but rather the party: 'you in breach of trust have obtained a judgment — the Chancellor does not say that the judgment was wrongly granted, he does not annul it, he tells you for reasons personal to yourself it will be inequitable for you to enforce that judgment, and that you are not to enforce it': Maitland (n 11) 9.
[13] *Supreme Court Act 1935* (SA) s 28; *District Court Act 1991* (SA) s 35; *Magistrates Court Act* 1991 (SA) s 30.
[14] *Kakavas v Crown Melbourne Limited* (2013) 250 CLR 392, [122] (Rich J) citing Dixon CJ, McTiernan and Kitto JJ in *Jenyns v Public Curator (Qld)* (1953) 90 CLR 113, [118]-[119].
[15] See Table 5.

[15.50] Both undue influence and duress operate to protect a voluntary decision. However, a notable distinguishing feature lies in the elements required to establish the respective actions. For example, prior to the creation of undue influence in equity, if a transfer of real property by gift was procured by exerting unacceptable influence or pressure on a person to the extent that it negated their free will, there was little recourse offered by the common law, as this was generally insufficient to satisfy the elements of duress. This is where equity intervened to bridge the gap left by duress, offering broader protection from subtle, as opposed to overt, forms of pressure that vitiated free will and agency that tainted the decision-making process.

A recent expression of a key distinction between undue influence and duress was provided in *Thorne v Kennedy.*[16] Justice Edelman, delivering judgment for the majority, explained that duress 'does not require that the person's will be overborne',[17] unlike undue influence which focusses on whether the plaintiff exercised a free and voluntary will. Expanding on this, Gordon J, in a separate judgment, remarked that the '"critical element in the grant of relief" is the impairment of the will of the weaker party''[18] Her Honour continued, reflecting that

> where undue influence is sought to be proved by reference to the particular circumstances surrounding a transaction, the question for the court will be whether those circumstances disclose that 'the transaction was the outcome of such an actual influence over the mind of the [weaker party] that it cannot be considered [their] free act.' As is well established, the transaction will be voidable if it was not the product of the free exercise of independent will.[19]

[16] *Thorne v Kennedy* (2017) 350 ALR 1, 9 (Keifel CJ, Bell, Gageler, Keane and Edelman JJ) ('*Thorne*').
[17] Ibid 9-10.
[18] Ibid 25 (Gordon J).
[19] Ibid.

By contrast, to establish duress, it must be shown that there was an 'unlawful threat or conduct in relation to a person's body, such as loss of life or limb'.[20] At all relevant times, the party subject to the duress is able to 'assess alternatives and make a choice'.[21] The key issue for consideration is that they cannot exercise that choice because of the existence of the threat, not whether their free will was undermined by the influence of another. Thus, while undue influence and duress are both concerned with behaviour of an external party and the impact it had on a decision-maker, a key distinction between the focus taken by each jurisdiction is the nature and character of the behaviour. Although undue influence and duress are both from a different origin, they have been placed side by side as key protections of a voluntary decision in proposed VAD legislation, which suggests a lack of sophisticated understanding of the two doctrines. Undue influence is concerned with overbearing influences that undermine free will and volition, whereas duress focuses on threats of violence that force a party to choose a course of action, which also undermines volition. Overlooking any issues that may arise concerning the appropriateness of these terms as statutory safeguards in proposed VAD legislation, when considered in tandem, it is evident that the scope of protection offered by both undue influence and duress is ostensibly broad.[22] Consequently, it is not difficult to understand the appeal of including protection against undue influence and duress in VAD legislation, as proposed in several past VAD bills in South Australia.[23]

[20] Ibid 9. The majority did raise an ongoing tension with common law duress and whether 'other illegitimate or improper, yet lawful, threats or conduct might suffice' as grounds to set aside a transaction on the ground of duress. The majority declined to resolve this tension in the present case. Justice Nettle agreed with the majority regarding their observation with common law duress and also declined to address this issue: see ibid 21–23 (Nettle J). Justice Gordon was silent on this issue and limited his judgment to consideration of the doctrines of undue influence and unconscionable conduct: see ibid 24–33 (Gordon J).
[21] Ibid 9.
[22] See, eg, Death with Dignity Bill 2016 (SA) s 11(2)(c) ('DWD Bill').
[23] See Table 5.

For example, under the Death with Dignity Bill 2016 (SA), the medical practitioner granting the request and two eligible witnesses were required to certify on the completed VAD request form that the person was not acting under duress or undue influence.[24] Furthermore, at the preliminary medical examination, the medical practitioner granting the request, and the medical practitioner providing the second medical opinion, were required to assess whether duress and/or undue influence were actively being exerted on the patient requesting VAD.[25] If a reasonable suspicion was raised by either practitioner, then referral to a psychiatrist was mandatory to confirm or deny the suspicion.[26] Protecting a voluntary decision is a core principle; however, neither undue influence nor duress are defined in this Bill, nor subject to any guidance or clarification. While members of the legal profession have the training, skills, and resources to interpret and understand the vital legal distinctions between undue influence and duress, that is not relevant in this context. The important question is, given the imposition of a positive duty to screen for these behaviours, do medical practitioners and the general public possess these abilities? Given the complexity and, at times, opaque nature of doctrine, the answer is, to put it simply, no.

This historical discussion regarding the development of equity and how it responded to deficiencies in the common law was necessary to provide important insight into the nature of equity, and ultimately, the doctrine of undue influence as developed in that jurisdiction. Equity provided recourse for claimants if the outcome of the common law resulted in injustice or offended the conscience, thus, bridging a gap left by the common law. Equitable undue influence sought to supplement duress by recognising that unacceptable influence that vitiated free will was as egregious as threatening someone

[24] DWD Bill ss 10(1)(g)(v), 14(1)(c)(v).
[25] Ibid ss 11(2)(c), 12(2)(c), 12(3).
[26] Ibid s 13(1)(b)(iii).

with physical violence to enter into a transaction, thus traversing into territory that duress could not. This discussion will now focus on the doctrine of undue influence itself and not the development of equity as a body of law.[27] Considering equity's distinct categorisation of undue influence into different classes serves to illustrate that the legislature must provide further clarification and guidance as it is a complicated doctrine that defies a precise definition.

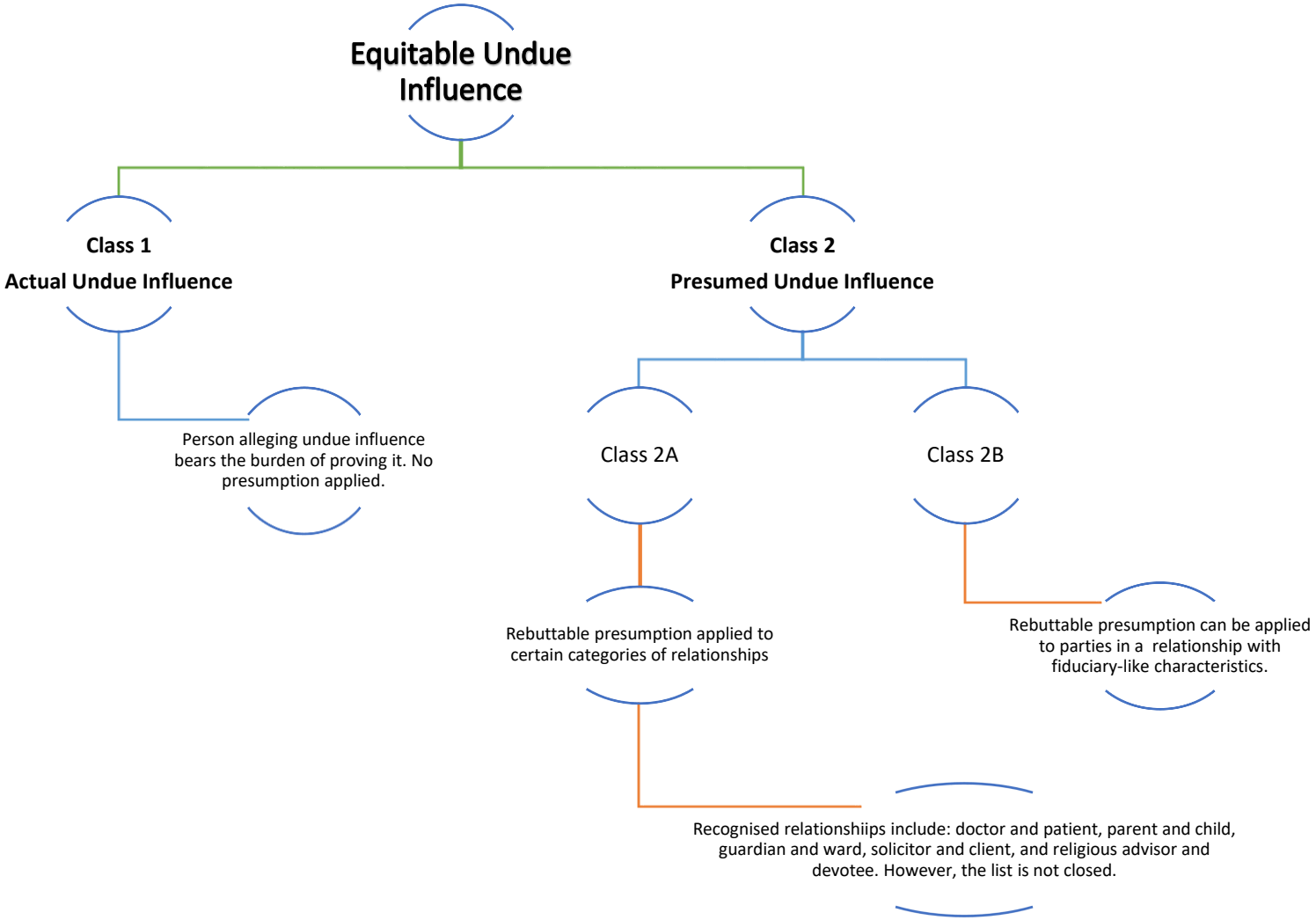
Equitable undue influence

[15.60] The doctrine of undue influence has a long judicial history. Despite this, equitable undue influence is anything but straightforward, as the development of the doctrine saw it separate into two distinct categories, which the court in *Bank of Credit and Commerce International SA v Aboody*[28] labelled Class 1 and Class 2 undue influence, or actual and presumed undue influence respectively.[29] The key difference separating Class 1 'actual undue influence' from Class 2 'presumed undue influence' is whether a rebuttable presumption can be established, which requires examination of the relationship of the parties central to the dispute. Class 2 undue influence divides further, consisting of two separate categories — Class 2A and Class 2B — of undue influence.[30] The important distinguishing feature separating Class 2A undue influence from Class 2B is whether the relationship of the parties falls into a category of relationship where the presumption will automatically apply or has fiduciary-like characteristics.[31] For clarity of discussion, Diagram 1 below depicts the categorisation of undue influence in equity. In order to

[27] For an overview on the origin of equity in England and its eventual implementation and evolution throughout Australia (and England), see Heydon, Leeming and Turner (n 5) [1-005]-[1-325]; see also Klinck (n 11).
[28] [1990] 1 QB 923, 953 (Slade LJ).
[29] Ibid; see also *Australia & New Zealand Banking Group Ltd v Neldue Pty Ltd & Ors* [2002] WASC 50, [15] (Master Sanderson) ('*ANZ v Neldue*').
[30] *ANZ v Neldue* (n 29). This categorisation of undue influence was clearly established in *Allcard* (n 1).
[31] *ANZ v Neldue* (n 29) [15] (Master Sanderson).

ensure that a complete picture of equitable undue influence is provided, both classes of undue influence will be discussed. This compartmentalisation of undue influence is unique to equity and, in Australia, is not applied in any other area where undue influence operates.

Diagram 1 – Overview of the Categories of Equitable Undue Influence



Class 2A undue influence: relationships of presumed undue influence

[15.70] The doctrine of undue influence has a long lineage in equity. It is not the purpose of this discussion to provide a complete analysis of Class 2A undue influence. The objective is to offer insight into the nature of the protection offered by equitable undue influence with a view to contrast key distinctions with it across the areas of law in which it is applied. This discussion is important because, from a legal perspective, when undue influence is raised, the important question that follows is 'which version of undue influence is present?' This is a necessary step in legal reasoning because the legal tests are different. However, this distinction was overlooked in the VAD bills introduced in South Australia, which does not reference the type at all, and this reflects an unsophisticated and incomplete understanding of the doctrine.

As was explained in at **[15.30]**, the nature of the doctrine of undue influence is, broadly speaking, to protect free will by providing recourse for parties who have been subjected to unacceptable influence, which undermined their free will and volition. Thus, if a person has been subjected to undue influence, equity could intervene to render the transaction voidable, on the ground that it is unconscionable to allow involuntary dispositions to stand. However, in equity, the nature of the protection is so broad that a presumption of undue influence is applied to defined classes of relationships. The presumption is not applied on the basis of any wrongdoing or *male fides* but because of the significant power imbalance inherent these relationships. This is the important distinguishing feature of Class 2A undue influence.

The categories of relationships that will attract the presumption in Class 2A undue influence were first identified in the mid-eighteenth century, but continue to be developed today.[1] With Class 2A undue influence, the courts have reiterated that the list of established classes of relationships is not closed, which is reminiscent of equity's flexible nature and focus on protection of the vulnerable.[2] The classes of relationships currently recognised are parent and child, guardian and ward,[3] physician and patient, religious advisor and devotee,[4] and solicitor and client.[5] One of the earliest expressions of undue influence can be found in *Morris v Burroughs*[6] ('*Morris*'), which addressed the parent-child relationship in particular.

In *Morris*, Lord Hardwicke remarked that 'as the parental authority is great, to *prevent* any undue influence it may have in prejudice of the children, there must, in all instances of this kind, be a valuable consideration moving from the father, and an actual benefit accruing to the child'.[7] *Morris* was not, however, decided on the grounds of undue influence, as it did not yet exist as an established doctrine,[8] nor did Lord Hardwicke

[1] See *Allcard* (n 1); *Johnson v Buttress* (1936) 56 CLR 113 ('*Johnson'); Bank of New South Wales v Rogers* (1941) 65 CLR 42, 42 (Starke J); *Thorne* (n 16) 12.
[2] See *Thorne* (n 16) 12–3. The issue of whether the presumption would automatically be applied to the relationship of fiancé and fiancée was recently rejected by the High Court: see *Thorne* (n 16) 13.
[3] *Maitland v Irving* (1846) 15 Sim 436; *Bainbrigge v Browne* (1881) Ch. D. 197.
[4] See *Allcard* (n 1); see also *Nottidge v Prince* (1860) 2 Giff. 246, 269 (Stuart VC). However, more recent Australian authority indicates that this category remains 'probable' only: see *Grace v Grace* [2012] NSWCA 976, [86] (Brereton J).
[5] For overview of these relationships, see *Johnson* (n 31) 134-5 (Dixon J).
[6] (1737) 26 E.R. 253.
[7] *Morris* (n 4) [403] (Lord Hardwicke); see also Winder (n 4); Heydon, Leeming and Turner (n 4) [1-5-030]; *Commercial Bank of Australia v Amadio* (1983) 151 CLR 447, 461 (Mason J).
[8] There is some evidence suggesting that the doctrine of undue influence existed much earlier than 1737. In 1932, John Ritchie published *Reports of Cases Decided by Francis Bacon, Baron Verulam, Viscount St. Albans, Lord Chancellor of England, in the High Court of Chancery* (London, Sweet and Maxwell, 1932), which contains an overview of the cases decided by his Lordship during his appointment as Lord Chancellor (1617–1621). In his publication, Ritchie cites two cases where undue influence was in issue. The first case mentioning undue influence was *Lyde or Joyner v Lyde or Joyner* (1617A), fol. 471, 754, 775, 918. ('*Lyde*'). It was held that the defendant utilised 'fraudulent practices' to disinherit the plaintiff: see *Lyde or Joyner v Lyde or Joyner* (1615A), fol. 900; *Lyde or Joyner v Lyde or Joyner* (1616A), fol. 261, 398, 889; *Lyde or Joyner v Lyde or Joyner* (1617A), fol. 471, 754, 775, 918., 918. The facts of the case were not stated, and Ritchie's overview does not elicit any information on the doctrine of undue influence itself, apart from it being included as a term in the case note: see John Ritchie, *Reports of Cases Decided by*

expand on what he meant by the term undue influence.[9] Nonetheless, it is evident from the judgment that Lord Harwicke, sitting as Chancellor in the equity jurisdiction, viewed transactions between parents and their children with suspicion. Equity was willing to intervene to protect children from entering into what can be called 'disadvantageous transactions', where they may not have been in a position to exercise their independent and free consent. Winder explains that the theoretical underpinning that was central to Lord Hardwick's decision was that the parent was viewed as being in a position of authority, so much so that the child could not act as a free agent, especially when the child was not, or only recently, emancipated.[10]

In the cases decided in the decades following *Morris,* the courts eventually adopted a rebuttable evidential presumption in favour of the child in this class of relationship. The rationale for adopting this presumption was based on an acknowledgment of the significant power imbalance in such a relationship, which the courts were ever mindful

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Francis Bacon, Baron Verulam, Viscount St. Albans, Lord Chancellor of England, in the High Court of Chancery (Sweet and Maxwell London, 1932) 6. In the second case — *Joy v Bannister v Bannister and Anor* (No 1) — undue influence was pleaded, and Ellesmere LC found for the plaintiff (decided three months prior to retirement, with whom Bacon LK, his successor, agreed). It was held that the defendant, Bannister, had induced by undue influence Mr Lydiatt (the deceased) to execute a deed of transfer and a will for all his property in her favour. The facts of the case presented in the decree are similar to recent cases where the doctrine has been successfully applied. Lord Keeper Bacon enunciated a list of factors that supported the conclusion that the disposition was not voluntary and was the result of 'undue influence'. These factors were: 1) Mr Lydiatt's advanced age (80); 2) his weakness of body and understanding; 3) isolating him from family and friends and inviting him to live with her (the defendant) in the countryside, where she promised to marry him after she was widowed; 4) turning his affections away from his heir-at-law (Elizabeth Joy and her husband) by telling him that they would rob him and poison him: see Ritchie, 33–5. Furthermore, speaking of the growth of equity, the leading scholars in equity in Australia — Heydon, Leeming and Turner — write that considerable growth of the equitable jurisdiction occurred in 1660–1873 and resulted in equity devising many new doctrines and principles, with undue influence being one of them. One of the heads of growth of equity in this period was the 'jurisdiction to relieve against the rigidity of the law: under this head fell relief against penalties, forfeiture, fraud, undue influence, accident and mistake', which supports the argument that precise origin of undue influence remains uncertain, but historically it fits within the period of time in which these seminal cases were decided: see Heydon, Leeming and Turner (n 4) [1-5-075].This uncertainty concerning the precise origin of the doctrine of undue influence does not effect this discussion. The rationale for highlighting this was for completeness of discussion.

[9] For an overview on how the courts described the parent and child relationship prior to *Morris*, see Winder (n 4) 98–9.

[10] Winder (n 4) 98–9.

of, as evident in Lord Hardwicke's judgment in *Morris*.[11] Therefore, if a parent was to retain a benefit from their child, they had the onus of proving that the transaction was free and voluntary. Thus, the substance of this early incarnation of undue influence was to protect the vulnerable child from situations where consent may not have been voluntarily given. Importantly, the presumption of undue influence — which has expanded from parent and child to include the list of other relationships set out above — is not based on any wrongdoing on the part of the 'influencing' party, but rather exists to prevent any abuse that may arise from such a relationship.[12] The existence of a relationship and the potential for abuse is at the heart of the inclusion of undue influence in the VAD bills but, in the absence of clear definition or guidance, concerns arise regarding its validity as a statutory safeguard.

It was highlighted above that one of the recognised relationships in Class 2A undue influence is that of medical practitioner-patient. In equity, this rule pertains to transactions, including gifts, between medical practitioners and patients where the patient is either donor or the transaction is disadvantageous to the patient and the 'transaction cannot reasonably be accounted for by ordinary motives'.[13] In equity, transactions between medical practitioners and patients are treated cautiously, given the relationship of trust and confidence which is rightly encouraged between a medical practitioners and patients, as well as the power imbalance inherent in the relationship.[14]

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[11] On this point, Tyson adds that there were a number of specific concerns underlying courts of equity adopting the presumption of undue influence — one of these concerns being evidential difficulties that would arise for the party alleging undue influence if the presumption did not exist: see Matthew Tyson, 'An Analysis of the Differences Between the Doctrine of Undue Influence with Respect to Testamentary and *Inter Vivos* Dispositions' (1997) 5(1) *Australian Property Law Journal* 38, 40.

[12] *Johnson* (n 31); *Inche Noriah v Shaik Allie Bin Omar* [1929] A.C. 127, 133 (Hailsham LC) ('*Inche Noriah*'). This absence of wrongful conduct and undue influence was recently discussed in *Anderson v McPherson (No 2)* [2012] WASC 19, 48–9 (Edelman J) ('*Anderson [No 2]*').

[13] See generally *Thorne* (n 15) 9.

[14] See generally Cameron Stewart and Andrew Lynch, 'Undue Influence, Consent and Medical Treatment' (2003) 96 *Journal of the Royal Society of Medicine* 598.

Here, undue influence is presumed before a court and the medical practitioner, as defendant, must establish that the transaction was voluntary, rather than the patient bearing the burden of establishing that the transaction was procured by undue influence. The underlying principle behind this rule was explained by Sir Turner VC in *Billage v Southee,*[15] a case concerning a surgeon and his patient, where his Lordship stated 'no part of the jurisdiction of the Court is more useful than that which it exercises in watching and controlling transactions between persons standing in a relation of confidence each other; and in my opinion this part of the jurisdiction of the Court cannot be too freely applied.'[16] Although this equitable rule is distinct from the way in which protection against undue influence intended to apply in VAD legislation, it nevertheless addresses an important issue of concern inherent in medical practitioner-patient relationships — that is, the significant amount of power and authority medical practitioners yield vis-à-vis their patient.

In the area of VAD, this has been perceived as a matter of concern that legislatures have attempted to reconcile.[17] This is, however, fundamentally different from the obligation placed on medical practitioners who were positioned as arbiters on questions of undue influence in VAD.[18] The special consideration given to medical practitioners and patients

[15] (1852) 68 ER 623.
[16] *Billage v Southee* (1852) 68 ER 623, 626 (Turner VC). Analogous to the reasoning in *Morris* above, protection of the vulnerable, weaker party — the patient — was influential in invoking the Court's jurisdiction in transactions between medical practitioners and patients. However, this simply created a rebuttable presumption of undue influence, not a prohibition on such transactions. To effectively rebut the presumption of undue influence, it was necessary for the medical practitioner to establish that the transaction was 'as an independent act resolved upon by a free and understanding mind': see *Johnson* (n 31) 133 (Dixon J); see also Stewart and Lynch (n 44).
[17] This was an issue of concern in Victoria and, in response to it, the legislature included a provision prohibiting registered health practitioners from suggesting VAD or initiating a discussion on VAD in the course of providing health or professional care services: see Voluntary Assisted Dying Bill 2017 (Vic) ss 8(1)(a), (b). The Explanatory Memoranda to the Voluntary Assisted Dying Bill 2017 (Vic) explained that the intention behind this prohibition was to 'protect individuals who may be open to suggestion or coercion by registered health practitioners, not to discourage open discussions driven by the individual': see Explanatory Memorandum, Voluntary Assisted Dying Bill 2017 (Vic) 2.
[18] See Table 5 for an overview of the South Australian Bills where screening for undue influence was mandated.

in Class 2A undue influence is very different from previous VAD bills in South Australia, where the medical practitioner was positioned as adjudicator on, not party to, questions of undue influence, requiring them to screen for undue influence in the patient's external environment regarding the request for VAD. Due to the significant shift in focus on the operation of undue influence, it is imperative that undue influence in VAD legislation is clearly and unequivocally defined.

Therefore, in Class 2A undue influence it is well recognised that certain established classes of relationships will attract the presumption of undue influence. In this incarnation of undue influence, the doctrine provides protection for vulnerable parties in identified relationships that are predicated on a significant imbalance of power. However, consistent with equity's broad and flexible approach, a presumption of undue influence can also be applied to certain circumstances beyond these identified relationships to relationships that have fiduciary-like characteristics. This has been labelled Class 2B undue influence, which will be discussed next.

Class 2B undue influence: relationships with fiduciary-like characteristics

[15.80] In addition to the established classes of relationship in which undue influence is presumed, equity also permits the presumption to be applied to relationships that have fiduciary-like characteristics. In order to determine whether this is the case, the court will consider whether 'the history of the particular relationship involved one party occupying a similar position of ascendancy or influence [as in Class 2A undue influence], and the other a corresponding position of dependency and trust'.[19] Here, equity extends the application of the presumption of undue influence to encompass a wide variety of

[19] *Thorne* (n 15) 12; see also *Johnson* (n 31) 134-135; *Watkins v Combes* (1922) 30 CLR 180 ('*Watkins*').

relationships where fiduciary-like characteristics are found. However, courts have been persistent in asserting that not all relationships where fiduciary-like characteristics or relations of trust and confidence are evident will give rise to a presumption of undue influence.[20] That is, whilst undue influence can be found where there is a relationship with fiduciary-like characteristics, it does not amount to a presumption. Put another way, a relationship with fiduciary-like characteristics can exist without undue influence and undue influence can exist outside of a fiduciary relationship — they can co-exist, but they are mutually exclusive.

The courts have recognised that in relationships where fiduciary-like obligations are owed, there is a significant risk that consent was not voluntarily given.[21] As a matter of policy, undue influence is presumed unless it can be successfully rebutted.[22] This was best explained by Dixon J in *Johnson v Buttress*[23] ('*Johnson*') where his Honour observed that the

> burden is imposed upon one of the parties to certain well-known relations as soon as it appears that the relation existed and that he has obtained a substantial benefit from the other … [however] the doctrine which throws upon the recipient the burden of justifying the transaction is confined to no fixed category. It rests upon a principle. It applies whenever one party occupies or assumes towards another a position naturally involving an ascendancy or influence over the other, or a dependence or trust on his part … *the relations between him and the donor are so close as to make it difficult to disentangle the inducements which led to the transaction. These considerations combine with reasons of policy to supply a firm foundation for the presumption against a voluntary disposition in his favour*.[24]

[20] See especially *Anderson [No 2]* (n 42) [249]–[253] (Edelman J); *In re Coomber*; *Coomber v Coomber* [1911] 1 Ch 723; *Christoudoulou v Christoudoulou* [2009] VSC 583, [72]–[73] (Kaye J).
[21] See *Spong v Spong* (1914) 18 CLR 544, 549 (Griffiths CJ) ('*Spong*').
[22] *Royal Bank of Scotland Plc v Etridge (No 2)* 1998 WL 1043594, [5]–[7] (Stuart-Smith, Millett, Morritt LLJ).
[23] (1936) 56 CLR 113.
[24] *Johnson* (n 31) [134]–[135] (Dixon J) (emphasis added); see also *Union Fidelity Trustee Co of Australia v Gibson* [1971] VR 573 ('*Union Fidelity Trustee*').

The presumption applied to certain relationships with fiduciary-like characteristics does not exist in the abstract. A necessary element is that a 'substantial benefit' has been obtained by the dominant party from the weaker one. In equity, with its focus on *inter vivos* transactions, the substantial benefit is often the transfer of valuable property by way of gift,[25] as in *Johnson*, or on other disadvantageous terms.[26] This is an essential point of distinction from the proposed use of undue influence in VAD — the focus of this doctrine in equity is almost entirely on transactions where valuable property moves from one party to the other, under conditions which enliven equity's jurisdiction via conscience. That is quite distinct from the way in which undue influence is proposed to be used in the VAD bills and calls into question the suitability of this doctrine outside of transaction-focused circumstances.

Furthermore, an important element of Class 2B undue influence is that it is not necessary for the weaker party to prove the dominant party exerted undue influence. Thus, the presumption — if successfully argued — is once again not predicated on the existence of any wrongdoing. In *Allcard v Skinner*,[27] Lindley LJ explained the underlying rationale of the courts adopting this protective position, remarking that

> '[c]ourts of Equity have set aside gifts made to persons in a position to exercise undue influence … although there has been no proof of actual exercise of such influence … the Courts have done this on the avowed ground … to protect persons from the exercise of such influence under circumstances which render proof of it impossible'.[28] Consequently, this shift in the burden of proof in Class 2B undue influence in favour of the weaker party requires the dominant party to prove that the consent was 'the pure, voluntary, [and] well-understood act of the mind'.[29]

[25] See, eg, *Spong* (n 51). For other circumstances where the doctrine of undue influence has been applied, see *Union Fidelity Trustee* (n 54); *Allcard* (n 1); *ANZ v Neldue* (n 28).
[26] A more recent application of this rule saw undue influence applied to void a post-nuptial agreement: see *Thorne* (n 15).
[27] (1887), 36 Ch D. 145.
[28] *Allcard* (n 1) 183.
[29] *Johnson* (n 31) 119 (Latham CJ), quoting *Huguenin v Beasley* (1807) 33 E.R. 526 (Eldon LC).

Further discussion on the cases where the presumption has been successfully rebutted will not be provided.[30] However, it is evident that Class 2B undue influence is dominated by cases that are transactional in nature, requiring the courts to undertake an intricate examination of the existing relationship between the parties and the circumstances surrounding the impugned transaction. Whilst this discussion is quite narrow and has only canvassed the law on both sub-categories of Class 2 undue influence, the complexities with the term 'undue influence' are already beginning to emerge, as are the existing limitations in its use within equity.

The past VAD bills tabled in the South Australian legislature, where screening for undue influence was included as a safeguard, provided no clarification or guidance although this formed an important part of the suite of protections included to protect voluntary choice. Not only is it impractical to oblige medical practitioners and the general public to screen for undue influence when courts and legal practitioners struggle with the concept but it comes with a significant judicial history which it cannot be separated from, and which does not readily match the circumstances of a VAD request. As there is no guidance in either the bills or the underlying parliamentary debates, it appears that the legislature have inserted undue influence without due consideration of how it will operate in this novel context. These arguments will be explored in more detail in the following chapters. Now that the categories of presumed undue influence have been explained, I will turn to discuss the final incarnation of undue influence recognised by equity: Class 1, actual

[30] In *Union Fidelity Trustee* (n 54) Gillard J at 578 remarks that 'it is undoubtedly true that in many of the authorities the presence or absence of independent advice has had a great influence on the court's decision on this vital question'. However, his Honour qualifies this referring to the Privy Council's exposition in *Inche Noriah* (n 42) stating 'the donee may rebut the presumption *in any manner open to* him on the facts which enables him to persuade the court that the gift was really the spontaneous act of a party, comprehending what he did and as a result of his own free will' (own emphasis). In the former case, the plaintiff, Inche Noriah, had sought independent advice concerning the impugned transaction; however, the solicitor she engaged was not aware of the fact that the deed of transfer by way of gift comprised of nearly her entire estate. It was, therefore, held that the independent advice given was not sufficient to rebut the presumption of undue influence. See also, *Watkins* (n 49).

undue influence. This is distinct in operation from Class 2 undue influence and serves as further evidence that use of this term as a proposed statutory protection for a voluntary decision should be avoided.

Class 1 actual undue influence

[15.90] The vital distinguishing feature between Class 1 and Class 2 undue influence in equity is that, with cases of Class 1 actual undue influence, no presumption will be applied. Therefore, the person seeking to have the transaction rescinded or set aside, typically the plaintiff, must prove that actual undue influence was utilised to procure consent.[31] The nature of the doctrine remains the same as with presumed undue influence — that is, protection of free will — however, the onus is on the plaintiff to prove that consent was not voluntarily given, but was secured as a result of actual undue influence by the defendant.

Lord Hailsham explained the rationale for the court's interference in cases of Class 1 undue influence, remarking that the underlying principle is that 'no one shall be allowed to retain any benefit arising from his own fraud or wrongful act'.[32] A longstanding issue with actual undue influence is that the courts have been reluctant to attribute a precise definition to it.[33] Despite the use of similar language in categories of Class 1 and Class 2 undue influence, there is reluctance to attribute precise definition to it. For example, Hodges J in *Union Bank of Australia v Whitelaw*[34] describes undue influence as 'acts [that]

[31] See *Royal Bank of Scotland Plc v Etridge (No 2)* 1998 WL 1043594, [5]–[7] (Stuart-Smith, Millett, Morritt LLJ); see also *Union Fidelity Trustee* (n 54) 574.
[32] *Inche Noriah* (n 42)133 (Hailsham LC).
[33] *Thorne* (n 15) 10.
[34] [1906] VLR 711, 712 (Hodges J).

are not, in the fullest sense of the word … free, voluntary acts'. In *Spong v Spong*, Rich J distilled the key question for consideration before the court as being 'whether the person parting with property by way of gift, or entering into a contract, had a full and free opportunity of judging for himself'.[35] On a similar note, Dixon J in *Johnson v Buttress* espoused that it must be the 'independent and well understood act of a man in a position to exercise free judgment'. Gillard J in *Union Fidelity Trustee Co. Of Australia Limited v Gibson*[36] framed the issue for consideration as being whether the act was 'pure, voluntary and well understood'.[37]

The key distinction, therefore, between Class 1 and Class 2 undue influence is who holds the burden of proof: the plaintiff for Class 1, proving they were unduly influenced; and the defendant for Class 2, proving that the plaintiff was exercising an independent will. When considering the evidential burden required to rebut the presumption of undue influence by a plaintiff, Lord Hailsham LC, in *Inche Noriah v Shaik Allie Bin Omar*,[38] explained that it must be 'proved that in fact the gift was the spontaneous act of the donor acting under circumstances which enabled him to exercise an independent will and which justify the court holding that the gift was the result of a free exercise of the donor's will'.[39] Therefore, although it has been framed in a variety of ways, the theme that emerges in the authorities is that *not* acting voluntarily, having freedom of will or exercising an independent judgment are quintessential elements of undue influence. Undue influence is thus defined by an absence of certain decision-making characteristics and if it has been established that free will was overborne, then this will likely constitute undue influence and the transaction will be set aside. Importantly, whilst it can be said that acting involuntarily is

[35] *Spong* (n 51) 552 (Rich J).
[36] [1971] VR 573.
[37] *Union Fidelity Trustee* (n 54) 574 (Gillard J); see also *Johnson* (n 31).
[38] (1929) A.C. 127, 133.
[39] *Inche Noriah* (n 42) 133.

a fundamental element of undue influence, the courts have provided further discussion on the basic features of undue influence. The starting point is an identification of influence exercised over the decision-making process, but the defining question is when does 'influence' become 'undue'. It is here, at this crucial juncture, that guidance becomes more opaque as the answer to this question has not been clearly articulated, with the classification of influence as 'undue' being judicially characterised as a question of fact and degree, determined on a case-by-case basis.

One important aspect of Class 1 undue influence, which assists in ascertaining whether the circumstances warrant the courts' protection, is that the influencing party must gain substantial influence over the other party's mind. However, what constitutes 'substantial' has been an issue of contention. In *Anderson v McPherson [No2]*,[40] Edelman J observed that in cases of actual undue influence, the requisite influence over the mind 'has been described as a position "in which it could fairly be said that the plaintiff's mind was in effect a mere channel through which the will of the defendant operated"'.[41] This suggests a significant, bordering on total, control or influence over the plaintiff's mind, with near complete abrogation of their volition. However, the High Court recently clarified this point, articulating the degree of influence or control over the mind necessary to constitute undue influence. In *Thorne*,[42] Edelman J, delivering judgment for the majority, explained that

> pressure can deprive a person of free choice in this sense where it causes the person substantially to subordinate his or her will to that of the other party. It is not necessary for a conclusion that a person's free will has been substantially subordinated to find that the party seeking relief was reduced entirely to an automaton or that the person became a 'mere channel through which the will of the defendant operated.' Questions of degree are involved. But, at the very least, the

[40] [2012] WASC 19.
[41] Ibid 49-50 (Edelman J) citing Morris LJ in *Tufton v Sperni* [1952] 2 TLR 516, 530. ('*Tufton*').
[42] (2017) 350 ALR 1.

> judgmental capacity of the party seeking relief must be 'markedly sub-standard' as a result of the effect upon the person's mind of the will of another.[43]

Therefore, whilst the majority clarified this threshold issue — and seemingly lowered it — the High Court reiterated that the vital question as to whether the influenced person's judgmental capacity has become 'markedly sub-standard' can only be resolved upon close examination of the facts of each individual case, for which there is no clear answer.

In addition to this, the courts have been steadfast regarding the distinction between mere influence or dominance of the mind and undue influence.[44] Indeed, influence alone is not grounds to invite the courts' intervention and is viewed as an acceptable element of human interactions.[45] This is where the doctrine of undue influence departs significantly from ordinary influence familiar to the English language; however, there is no clear test available to draw a clear dividing line between the two. As observed by Porter J in *Mutual Finance Ltd v John Wetton & Sons Ltd*,[46] 'how is the line to be … drawn between those forms of coercion or persuasion [influence] which are permissible and those which the law recognises as unlawful [undue influence] and as a ground of … invalidity? To this question it is impossible, as the authorities at present stand, to give any definite or confident reply'.[47]

This difficulty with Class 1 undue influence, raised nearly a century ago, applies equally today. It was recognised and, according to more recent authorities still is,[48] that it is a complex, fact-driven inquiry, which often involves careful examination of the minutiae of

[43] *Thorne* (n 15) 11 (Keifel CJ, Bell, Gageler, Keane and Edelman JJ).
[44] See, eg, *Watkins* (n 49) 193 (Isaccs J).
[45] See, eg, *Allcard* (n 1)
[46] [1937] 2 KB 389, 394-95.
[47] Ibid 394-95.
[48] See, eg, *Thorne* (n 15); *Anderson [No 2]* (n 42)

facts surrounding the case to determine whether influence transcended what was appropriate and acceptable in the circumstance.[49] Therefore, as it stands, Class 1 undue influence requires the influenced party to prove that their free will was markedly subordinated as a result of the pressure placed on them by the influencing party. Mere influence is permissible and the courts will not intervene if a party has been influenced into consenting to a transaction. The plaintiff must prove that an invisible line was traversed, which markedly subordinated their will, and tainted their ability to make a voluntary decision. Whether the lawful/unlawful dividing line was crossed requires thorough examination of the parties involved in the transaction and the relevant circumstances surrounding it. This is a very difficult test to satisfy and poses difficulties for even skilled advocates. There are a myriad of matters to consider. The courts have the benefit of having skilled legal professionals pleading the case and presenting evidence to support their version of events. Furthermore, the impugned transaction is historical, and the parties in the dispute are clearly defined, thus limiting the issues for consideration before the court.

In the context of VAD, in the absence of clear legislative guidance regarding what is meant by 'undue influence', screening for undue influence becomes unjustifiably difficult and it borders on impossible to know who may be exercising influence in the patient's familial and social circle. In a practical setting, this would require medical practitioners and witnesses to screen for undue influence from a wide cohort of persons, who are likely unknown to them, and repeat the test in each individual circumstance, assuming they know what undue influence is. This is impractical and, given the difficulties that are likely to arise as a consequence, there is a real risk that screening for undue influence is reduced to a box ticking exercise, devoid of value. That is not to say that medical practitioners

[49] For discussion on the facts that were central to the finding of undue influence see *Thorne* (n 15); *Watkins* (n 49); *Tufton* (n 71); *Inche Noriah* (n 42); *Johnson* (n 31).

would intentionally adopt a sub-standard approach concerning the care of their patients, nor that witnesses would be lackadaisical in examining for undue influence. The argument here is that, given the challenges with the term 'undue influence', there is a real risk that the approach adopted towards screening for undue influence will be *unintentionally* sub-standard as a consequence of the legislature's omission to clearly articulate what they mean. If this is not addressed, this places all parties at risk and calls for a re-examination of the choice of wording.[50] Equally, as the burden of proof shifts between Class 1 and Class 2, it would be necessary to understand in far greater detail than the VAD bills currently utilise, which version of the doctrine is to be applied.

Based upon this discussion, it is clear that the nature of the doctrine of undue influence in equity is to protect individuals from overbearing persuasion or influence that has substantially subordinated their ability to exercise free will and voluntary choice. Equity has recognised that external influences can, in the right circumstances, negate consent much as common law duress would, and there is no requirement to prove *male fides* of the party exercising the influence. Consistent with equity's flexible nature and focus on conscience, undue influence can be presumed in certain relationships, placing the burden of proof on the influencing party to demonstrate that the transaction was freely and voluntarily agreed to. The underlying rationale for this position is that certain relationships are based upon a significant imbalance of power and exemplify trust and confidence, which could be misused and the stronger party should not take advantage of the dependent, weaker one. In such cases, equity endeavours to protect the vulnerable. It is evident that the doctrine of undue influence comes with a significant judicial history and is multi-faceted and complicated, to say the least. Including undue influence as a safeguard for a voluntary decision in VAD legislation without considering its equitable

[50] These issues will be explored in greater detail in the following chapters.

origin is inappropriate. Even with greater clarity as to which type of undue influence was intended, significant questions remain as to the appropriateness of a transaction-based doctrine when applied to non-transactional circumstances. Further, given the complexities of the legal tests involved, it places an unrealistic burden on medical practitioners and witnesses. In the context of VAD, it would be asking medical practitioners and witnesses to perceive the relationship between the patient and others and make a judgment about undue influence — much as a court must. Given the difficulty that the courts have with equitable undue influence, as set out above, is that what parliament truly intends, and if so, is it appropriate? If it is not what parliament intends, they should reconsider their language choice.

A further complication is caused as equity is not the only jurisdiction where the doctrine of undue influence is applied. Undue influence has also been adopted by probate and is recognised as grounds to challenge the validity of a testamentary instrument. This is known as testamentary undue influence.

Testamentary undue influence

[15.100] It has been argued that the doctrine of undue influence 'must be understood as a form of art within the sphere in which it is being used'.[51] A key feature distinguishing testamentary undue influence from equitable undue influence is that equitable undue influence applies to *inter vivos* ('between the living')[52] transactions. Testamentary undue influence, on the other hand, applies to testamentary dispositions, and operates as a ground to challenge the validity of a will when the testator/testatrix is deceased. The

[51] Tyson (n 41) 38.
[52] See generally Carmelle Peisah et al, 'The Wills of Older People: Risk Factors for Undue Influence' (2009) 21(1) *International Psychogeriatrics* 7.

pivotal consideration before the probate court is whether the will was made voluntarily, or whether it was the product of undue influence. Probate, with its focus on protecting the testamentary intentions of the deceased, will not permit a will to stand if it was not made voluntarily. However, or perhaps consequently, testamentary undue influence is quite different from its equitable equivalent.[53] Bell explains that undue influence in probate, initially adopted by the Ecclesiastical Courts prior to the formation of the probate courts, is strict in application, and narrower in its definition, than its equitable counterpart.[54] This distinct incarnation of undue influence is further evidence that the South Australian legislature needs to reconsider the application of undue influence as a proposed safeguard in VAD. It can be difficult, and even impossible, to sever language from its historical origins, and this is particularly true for legal terms. Even where it is possible, it may be misguided to do so. Undue influence is an exceptional example of this point. It is indeed a form of art, similar to a lenticular print where the image changes depending on the angle from which it is viewed.

Strict application of testamentary undue influence

[15.200] In probate, undue influence will not, under any circumstance, be presumed on the basis of the existence of a special relationship.[55] This unique rule of testamentary

[53] See generally Fiona Burns, *'Elders and Testamentary Undue Influence in Australia'* (2005) 28 *University of New South Wales Law Journal* 145; Tyson (n 41); Andrew Bell, 'Abuse of a Relationship: Undue Influence in English and French Law' (2007) 3 *European Review of Private Law* 564. Tyson argues that testamentary undue influence has its origins not in the equitable doctrine of undue influence, but is rather the progeny of the older ecclesiastical doctrine of 'coercion' and this explains the difference in the application across the two areas of law: Tyson (n 41) 44. However, the cases on testamentary undue influence, discussed below, have adopted the position that testamentary undue influence is a version and extension of, the equitable doctrine.

[54] Bell (n 83).

[55] See especially *Wingrove v Wingrove* (1886) LR 1 P&D ('*Wingrove*'); *Parfitt v Lawless* (1872) LR 2 P&D 462 ('*Parfitt*'); *Montalto v Sala* [2016] VCSA 240 ('*Montalto*'); *Re Demediuk* [2016] VSC 587, [120]; see also *In the Estate of Morris Charles Hassan Deceased* [2008] SASC 14; *Winter v Crichton* (1991) 23 NSWLR 116.

undue influence was established early in the judicial history.[56] Lord Penzance in *Parfitt v Lawless*[57] clearly explained the justification for this difference in application, observing

> the influence which is 'undue' in the case of gifts *inter vivos* [equity] is different from that which is required to set aside a will. In the case of gifts or other transactions *inter vivos*, it is considered by the courts of equity that the natural influence arising out of the relation of parent and child … doctor and patient, attorney and client, confessor and penitent, or guardian and ward exerted by those who possess it to obtain a benefit for themselves is an 'undue' influence … unless the party benefited can show affirmatively that the other party to the transaction were placed in such a position as would enable him to form an absolutely free and unfettered judgment. The law regarding wills is different. The natural influence which such relations as those in question involve may lawfully be exerted to obtain a will or legacy, so long as the testator thoroughly understands what he is doing and is a free agent; and hence *the rules adopted in courts of equity in relation to gifts inter vivos are not applicable to the making of wills*.[58]

Therefore, the evidential burden of proving that a will or codicil was obtained by undue influence always rests with the party alleging it. As Lord Penzance observed, the 'special relationships' that invoke the equitable presumption, when applied in the context of wills cannot stand. Similarly, in the earlier case of *Hall v Hall*,[59] Sir Wilde observed that 'persuasion, appeals to the affections or ties of kindred, to a sentiment of gratitude for past services, or pity for future destitution, or the like — these are all legitimate, and may be fairly pressed upon a testator'.[60] Because testamentary dispositions inherently involve a degree of influence, it is only natural that a testamentary disposition would be made in favour of someone within the defined class — recognised in equity — based on kinship or friendship. Thus, in this specific area of law, it would be incongruous if the presumptive rule recognised in equity were applied to wills.

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[56] *Hindson v Weatherill* (1854) 43 ER 886, 890 (Turner LJ).
[57] (1872) LR 2 P & D 462.
[58] *Parfitt* (n 85) 464 (own emphasis); for more recent Australian authority on this rule, see *Montalto* (n 85).
[59] (1868) L.R. 1 P & D 481.
[60] *Hall v Hall* (1868) L.R. 1 P & D 481, 482 ('*Hall*').

This rule is well recognised in Australia. In the High Court of Australia case of *Bailey v Bailey*,[61] Isaccs J, with whom Duffy and Rich JJ concurred, devised a list of working propositions for the courts to apply when considering the validity of a testamentary instrument. Concerning the burden of proof in cases of testamentary undue influence, his Honour remarked that the 'onus means the burden of establishing the issue, it continues during the whole case and must be determined upon the balance of the whole evidence'.[62] In *Coppola v Nobile*,[63] Stanley J, citing Doyle CJ in *Thomas v Nash*,[64] applied this rule, observing that 'there is no role for a presumption of undue influence in relation to a will. To establish that a will was executed as a result of undue influence, it is necessary for the court to be satisfied that undue influence was in fact exerted'.[65]

The case of *Re Montalto*[66] provides a clear discussion of the court's position on this principle. In this case, the plaintiff sought to have his mother's will vitiated on the ground that, inter alia, it was procured by the undue influence of his brother. In part, the plaintiff argued that by removing their mother from residential care, some four weeks after the plaintiff had placed her there, and caring for her at his home and isolating her from the plaintiff — during which time a new will was executed — his brother, Tommaso, had unduly influenced her to execute the new will. The Court struck out the plaintiff's ground of objection for the grant of probate due to undue influence, stating that the particulars were insufficient to support the assertion that the testatrix was *coerced* [unduly influenced] to make the will.[67] The plaintiff appealed this finding.

[61] (1924) 34 CLR 558.
[62] Ibid 570.
[63] [2012] SASC 129, 135.
[64] (2010) 107 SASR 309.
[65] (2010) 107 SASR 309, 324 [80] (Doyle CJ), cited by Stanley J in *Coppola v Nobile* [2012] SASC 129, 135.
[66] [2016] VSC 266.
[67] *Re Montalto* [2016] VSC 266, [42].

On appeal, the applicant argued that the trial judge erred by failing to consider the context of the particulars, which, when considered as a whole, supported the inference that the will was procured by undue influence.[68] The particulars stated that

> (a) the applicant placed the testatrix in residential care in October 2012; (b) some four weeks into her stay in residential care, Tommaso [the second respondent] removed her from residential care; (c) thereafter the testatrix was under Tommaso's 'care and control'; and (d) the testatrix executed her will when she was being kept substantially isolated from the applicant until her death.[69]

The context adduced to support the inference of undue influence was that the testatrix had executed several previous wills in which Tommaso was excluded as a beneficiary.[70] It was argued that the respondent's restoration as a beneficiary under the present will could only be explained on the ground that he had unduly influenced the testatrix to execute the will in his favour.[71] In response to the applicant's submissions, it was argued that the applicant was wrong to assert that undue influence could be supported by inference on the facts, highlighting that the applicant was erroneously conflating the rules concerning equitable undue influence and testamentary undue influence, submitting that it must be shown that the testatrix was actively coerced to make the will. In finding for the respondents, the Court of Appeal explained that 'particulars which are consistent only with the opportunity to influence … are insufficient. Undue influence will not be presumed'.[72]

The rule pertaining to testamentary undue influence is well established, with the courts reiterating that a presumption will not be applied to testamentary undue influence.

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[68] *Montalto* (n 85).
[69] Ibid [31].
[70] Ibid [24].
[71] Ibid.
[72] *Montalto* (n 85) [32]. See also *Wingrove*,(n 85) where Hannen P instructed the jury 'it is not sufficient to establish that a person has the power unduly to overbear the will of the testator. It is necessary to also prove that in the particular case that power exercised, and that it was by means of the exercise of that power, that the will such as it is, has been produced' (83); *Re Estate Kouvakas; Lucas v Konakas* [2014] NSWSC 786, [113] (Lindley J).

However, further points of distinction exist between undue influence in equity and probate, with probate adopting a stricter definition of undue influence which is less suited to application in VAD.

Testamentary undue influence and coercion: the unique definition applied in probate

[15.300] Further evidence of undue influence being a 'form of art' resides in the unique definition of undue influence applied in probate. In order to prove testamentary undue influence, it must be shown that the testamentary instrument was executed by *coercion*, an additional element not visible in other forms of undue influence. This was succinctly explained by Lindley J in *Re Estate Kouvakas; Lucas v Konakas*,[73] where his Honour observed that 'an allegation of undue influence, made in support of a challenge to the validity of a will, require[s] proof of *actual coercive conduct* vitiating the free will of the testator'.[74] Although the elements of testamentary undue influence are clearly different to the elements of equitable undue influence, the underlying rationale of the doctrines are consistent. Like equitable undue influence, testamentary undue influence seeks to protect voluntariness and free agency by providing grounds for relief if there is evidence that a testamentary instrument was not the exercise of the 'free, independent and voluntary will of the testator'.[75] However, in probate, the definition of undue influence is narrower, thus limiting its application.

[73] [2014] NSWSC 786.
[74] Ibid [113] (Lindley J).
[75] *Nicholson v Knaggs* [2009] VSC 64, [150] (Vickery J).

For instance, in *Williams v Gaude*,[76] Sir Nicholl stated that the influence necessary to vitiate a will must be tantamount to 'force and coercion destroying free agency'.[77] In *Parfitt v Lawless,*[78] Lord Penzance explained that 'undue influence is very carefully defined, and it is very doubtful whether the same meaning is attached to those words in the courts of equity. In testamentary cases it is always defined as coercion'.[79] His Lordship continued, observing that 'undue influence as a term used in a plea in this court raises the question of coercion, and that only'.[80] In finding that no undue influence was present in the forming of the will, his Lordship concluded that the testatrix was 'carrying out her own wishes; she was intent on achieving an end of her own for the ease of her own mind … all of which is hardly consistent with the notion of her having acted under the dictation of another'.[81] Similarly, often considered the clearest expression of this rule, Hannen P in *Wingrove v Wingrove*[82] ('*Wingrove*') clarified this pivotal distinction, observing that

> to be undue influence in the eye of the law there must be - to sum it up in a word - coercion. It must not be a case in which a person has been induced … to come to a conclusion that he or she will make a will in a particular person's favour, because if the testator has only been persuaded or induced by considerations which you may condemn, really and truly to intend to give his property to another, though you may disapprove of the act, yet it is strictly legitimate in the sense of its being legal. It is only when the will of the person who becomes a testator is coerced into doing that which he or she does not desire to do, that it is undue influence. The coercion may of course be of different kinds, it may be in the grossest form, such as actual confinement or violence, or a person in the last days or hours of life may have become so weak and feeble, that a very little pressure will be sufficient to bring about the desired result, and it may even be, that the mere talking to him at that stage of illness and pressing something upon him may so fatigue the brain, that the sick person may be induced, for quietness' sake, to do anything. This would equally be coercion, though not actual violence.[83]

[76] (1828) 1 hagg. Ecc. 577.
[77] *Williams v Gaude* (1828) 1 Hagg. Ecc. 577, 581 (Sir John Nicholl) cited in Winder (n 4) 104.
[78] (1872) LR 2 PD 462.
[79] *Parfitt* (n 85)
[80] Ibid 471 (Penzance LJ).
[81] Ibid 476.
[82] (1885) 11 P.D. 81.
[83] *Wingrove* (n 85) 82.

Hannen P's judgment has been cited with approval in Australia. For instance, Doyle CJ in *Thomas v Nash*[84] cited Hannen P's above quote in *Wingrove*; however, further clarified the meaning of 'coercion' in testamentary undue influence, remarking that the 'expression "coercion" used by Sir James Hannen [in *Wingrove*] is suggestive of the use of force, but it is not limited to force. The underlying notion is that of compulsion. Compulsion can be achieved by threats, by persuasion or by psychological pressure'.[85] It is plainly evident that with testamentary undue influence, the courts have set a higher threshold to satisfy undue influence. This long-standing rule appears to be well accepted in Australia.[86]

It is clear that testamentary undue influence means something different than equitable undue influence. Since the introduction of undue influence into the probate courts, a more restrictive definition has been applied. In this regard, testamentary undue influence has even been described as a species of duress.[87] However, there remains an important caveat in that, unlike common law duress, it is not necessary to prove actual or threatened violence.[88] Just as with equitable undue influence, testamentary undue influence is inherently difficult to identify. The principle defies a clear definition, as whether influence is undue in the eyes of probate depends upon the distinct facts of a case. Furthermore, it can be exercised in a variety of different ways as explained by Hannen P's passage in *Wingrove*, quoted above, where the President remarked that 'coercion may of course be of different kinds, it may be in the grossest form … actual confinement or violence, or a person in the last days or hours of life may have become so weak and feeble, that very little pressure will be sufficient to bring about the desired result'.[89]

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[84] (2010) 107 SASR 309, 324 [81].
[85] (2010) 107 SASR 309, 322-324, [78]–[80].
[86] See especially *Trustee for the Salvation Army (NSW) Property Trust v Becker* (2007) 14 BPR 26, [63] (Ipp JA); *Carney v Hall* (2011) 111 SASR 424, 432 [29] (White J); *Winter v Crichton; Estate of Galieh* (1991) 23 NSWLR 116, 121 (Powell J).
[87] Winder (n 4) 105.
[88] *Boyse v Rossborough* (1857) 10 ER 1192.
[89] *Wingrove* (n 85) 82 (Hannen P).

The principles pertaining to testamentary undue influence are well established in probate. However, with testamentary undue influence, the courts have reiterated that the difficulty resides in the fact that it cannot be readily identified as this is a question of fact and degree in every case. The unique additions to testamentary undue influence, when considered vis-à-vis with equitable undue influence, further confound its meaning, supporting the argument that this is not a term that can readily be applied in broader lay contexts.

Undue influence is a term burdened by a substantial judicial history. The legislature must carefully and thoughtfully consider its use of language in proposed VAD legislation because legal terms that have their roots deeply embedded in judicial history and not the English lexicon do not yield to an ordinary or definitive meaning. Looking beyond equity and probate, the rules — or lack thereof — relevant to medical undue influence further call into question the appropriateness and utility of undue influence as a proposed statutory safeguard.[90]

Medical undue influence

[15.400] Medical undue influence is the most recent incarnation of the doctrine. Under existing common law, for a consent to medical treatment to be valid it must, inter alia, have been expressed voluntarily.[91] There are, however, specific circumstances where an otherwise valid consent to medical treatment will be invalid due to vitiating factors.[92]

[90] Undue influence applied in the medical law line of cases will be referred to as 'medical undue influence' in this thesis.
[91] See especially *Application of a Local Health District: Re a Patient Fay* [2016] NSWSC 624 ('R*e Fay*'); *Hunter* (n 2)*; Re T* (n 6); *H Ltd & Anor v J* [2010] SASC 176 ('*H Ltd*').
[92] A medical practitioner who proceeds to treat a patient on the basis of an invalid consent can be liable in tort for trespass to the person; namely, an action in battery and potentially assault: see *Chatterton v Gerson & Anor* [1981] All ER 257; *Dean v Phung* [2021] NSWCA 223.

Undue influence has been recognised as one such vitiating factor. The impetus behind the law adopting this position is consistent with the reasoning applied to equitable and testamentary undue influence — that is, the courts will not permit an involuntary decision to stand at law. However, significant limitations exist with medical undue influence in South Australia which impede this discussion.

To date, there is little judicial discussion on medical undue influence Australia-wide, let alone in South Australia.[93] The seminal case in this area is a UK decision.[94] Medical undue influence has never been considered by the High Court of Australia, nor by any South Australian court, except in the case of *H Ltd v J*,[95] where Kourakis J, as he then was, acknowledged in *obiter* that undue influence can vitiate a consent to medical treatment.[96] However, it was considered, albeit briefly, in the case of *Application of a Local Health District: Re a Patient Fay*[97] ('*Re Fay*') heard before the New South Wales Supreme Court.

In *Re Fay*, Sackar J found that the patient who refused to consent to medical treatment had been unduly influenced, as their will had been overborne. However, Sackar J stopped short of providing any guidance regarding the scope and parameters of undue influence in this area of law.[98] Thus, the position in Australia on medical undue influence remains unclear. That is not to say that medical undue influence is not recognised as a ground to vitiate a consent to medical treatment, there is sufficient evidence to support the assertion

[93] See *Re Fay* (n 121).
[94] See *Re T* (n 6).
[95] [2010] SASC 176.
[96] Ibid [40], [43]. Kourakis J agreed with McDougall's J statement of principles pertaining to consent to medical treatment in *Hunter,* [5]. In this case, McDougall J explicated that a consent may be ineffective at law if it was undermined or vitiated by undue influence: see *Hunter*, [26]-[27]; *Australian Capital Territory v JT* [2009] ATCSC 105, [38] (Higgins CJ); *UMG* [2015] NSWCATGD 54.
[97] [2016] NSWSC 624.
[98] Ibid [39]-[42], [82], [85].

that it is.[99] The pertinent issue is that there is currently a lack of judicial consideration concerning its scope and operation in this area of law, with no binding precedent in South Australia.

Due to this limitation, this discussion will focus on *Re T (Adult: Refusal of Medical Treatment)*,[100] the key UK authority on medical undue influence, and *Re Fay*. The lack of Australian authority on medical undue influence stands in stark contrast to equitable and testamentary undue influence, where there is a surfeit of cases establishing the key features of undue influence in these separate areas of law. If the South Australian legislature did intend this medical incarnation of undue influence to apply, then this is a deeply problematic position to take, as although undue influence comes with a significant history in equity and probate, it is not a developed principle in medical law in Australia, and in this sphere its operation is uncertain. This uncertainty in operation strengthens my assertion that undue influence is a complicated and convoluted doctrine and steps must be taken to clarify — or reconsider — its inclusion as a statutory safeguard in proposed VAD legislation. The pivotal issue remains: it is uncertain what undue influence means in the context of VAD, and consequently does not provide for an appropriate safeguard. If the object of screening for undue influence in a request for VAD is to provide broad protection of a voluntary decision, it remains to be seen how this purpose can be achieved if the terminology used is uncertain and ambiguous.

Application of medical undue influence: the UK position on medical undue influence

[99] Ibid; see also Cameron Stewart and Paul Biegler, 'A Primer on the Law of Competence to Refuse Medical Treatment' (2004) 78 *Australian Law Journal* 325; Stewart and Lynch (n 44); Cameron Stewart, Carmelle Pesiah and Brian Draper, 'A Test for Mental Capacity to Request Assisted Suicide' (2011) 37(1) *Journal of Medical Ethics* 34.
[100] [1993] Fam 95.

[15.500] In the UK, it has been determined that cases falling within this category of undue influence will not attract a presumption of undue influence.[101] Therefore, the plaintiff bears the burden of proving undue influence, thus making it more akin to testamentary and actual undue influence in equity. Furthermore, consistent with other incarnations of undue influence considered here, medical undue influence seeks to protect free will and agency, which is evident in the three separate judgments delivered by the Court in *Re T (Adult: Refusal of Medical Treatment*) ('*Re T*').[102]

In *Re T*, Butler-Sloss LJ described undue influence as being influence of a kind that 'sap[s] [the] will or destroys volition'.[103] Lord Donaldson MR preferred to frame the pivotal issue for consideration before the Court as a question, asking 'does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?,'[104] inferring that medical undue influence requires the near abolition of one's own ability to exercise free will and agency. Similarly, Staughton LJ labelled medical undue influence a form 'of external influence as to persuade the patient to depart from [their] own wishes'.[105] It is, therefore, evident from the quotes cited above that undue influence in this area of law requires the courts to examine whether the person's free will was significantly undermined by the external influence or persuasion of a third party. Given this construction of undue influence by the Court in *Re T*, medical undue influence appears to resemble Class 1 equitable undue influence, as opposed to testamentary undue influence, where the influence required to overbear free will must be

[101] See *Re T* (n 6); *Centre for Reproductive Medicine v U* [2002] All ER (D) 213 ('*CRM*').
[102] [1993] Fam. 95.
[103] *Re T* (n 6) 120 (Butler-Sloss LJ).
[104] Ibid 113 (Donaldson MR).
[105] Ibid 120 (Butler-Sloss LJ).

tantamount to coercion.[106] Thus, their Honours concurred regarding the key characteristic of undue influence as being a near complete abrogation of free will and volition. They, however, continued, elucidating specific factors relative to this incarnation of undue influence to guide courts, should future analogous disputes arise.

Factors influential in finding medical undue influence

[15.600] In the case of *Re T*, T was 34 weeks pregnant and admitted to hospital complaining of chest pain following a road traffic accident, and she was later diagnosed with pneumonia. Despite being administered medical treatment, her condition deteriorated to the point where she required a blood transfusion to save her life. T refused to consent to administration of blood products initially verbally and then later in writing. An important issue was the circumstances surrounding the refusal as each refusal to consent to blood products was immediately preceded by a visit by T's mother, a fervent devotee of the Jehovah's Witness faith. T's father and boyfriend applied to the Court to have the refusal overturned. Therefore, a key issue for determination before the Court was whether T's verbal and signed refusal was valid or was procured by the undue influence of her mother.[107] The Court determined that T's refusal to consent was invalid as it was vitiated by undue influence. In reaching this finding, the Court highlighted several defining factors. T's upbringing and her state of health at the time consent was

[106] For discussion on testamentary undue influence, see **[15.300]**.
[107] Several issues were before the Court in *Re T* — undue influence was one. The other issues the Court was invited to consider were whether T had the capacity to consent and whether false assumptions and misinformation vitiated her refusal to consent. For the purpose of this discussion, only undue influence will be considered here.

refused were relevant to the decision at hand and the Court took time to carefully consider her childhood.

T's parents had separated when she was young, largely due to T's mother's devotion to the Jehovah's Witness faith.[108] Post her parent's separation, T had primarily lived with her mother, who brought T up according to the tenets of the Jehovah's Witness faith, although T never officially converted to the religion.[109] In her later adolescence, T moved in with her paternal grandmother for one year and then her boyfriend — the father of her unborn child. During this time, T became close to her father again, who was not a Jehovah's Witness. In Court, T's father gave evidence stating that T was not a Jehovah's Witness, referring to recent discussions they had on the subject of her faith, which was also corroborated by her boyfriend.[110] Furthermore, there was no indication that T wished to become a Jehovah's Witness, as, prior to her admission into hospital, she lived a life contrary to the strict practices of the faith.

When T was admitted into hospital, T's mother visited her and, after being alone with her mother, T spontaneously communicated to the medical staff her refusal of blood products, stating that she retained some beliefs of the Jehovah's Witness faith.[111] This was the first of two express refusals to blood products that arose immediately after T had been left alone with her mother. Shortly after the first express refusal, T went into premature labour and was transferred to the maternity ward by ambulance. T's mother accompanied her in the ambulance and, after arriving at the maternity ward, T reiterated her refusal of blood products to the treating doctor and nurse. The suddenness of T's refusal of blood

[108] *Re T* (n 6) 103.
[109] Ibid 103.
[110] Ibid 104.
[111] Ibid 105, 118.

products were key facts before the court concerning the issue of whether T was unduly influenced to refuse consent of blood products.

In concluding that T's refusal of consent was vitiated by undue influence, the Court referred to the equitable and probate cases on undue influence; however, rejected their utility in this novel situation. Concerning the equitable presumption, it was determined that the cases on equitable undue influence were not relevant, drawing a clear distinction between the equitable doctrine of undue influence and the way that it is considered in the context of consent to medical treatment. On this point, Staughton LJ remarked

> the cases on undue influence in the law of property and contract [which are dealt with in the equitable jurisdiction] are not, in my opinion, applicable to the different context to consent to medical or surgical treatment. The wife who guarantees her husband's debts, or the widower who leaves all his property to his housekeeper, are not in the same situation as the patient faced with the need for medical treatment.[112]

Although it is clear that Staughton LJ rejected the utility of equitable undue influence, predominantly on the basis of its transactional focus, he did not further consider the issue of undue influence, and instead agreed with Lord Donaldson MR and Butler-Sloss LJ, finding that there was no valid refusal of consent.[113] Butler-Sloss LJ addressed the issue of undue influence directly, agreeing with Staughton LJ (in the quote above) finding that 'neither the probate line of cases nor the donor [equitable] line of cases is appropriate to apply to the present situation which is entirely different'.[114] However, Butler-Sloss LJ qualified this by indicating that the probate and equitable decisions were helpful 'to demonstrate that both at law and in equity it has long been recognised that an influence may be subtle, insidious, pervasive and where religious beliefs are involved especially

[112] Ibid 121 (Staughton LJ); see also 119-120 (Butler-Sloss LJ) who agreed with His Lordship.
[113] Ibid 122 (Staughton LJ).
[114] Ibid 119-20 (Butler-Sloss LJ).

powerful'.[115] Despite failing to recognise the equitable presumption in this circumstance, Butler-Sloss LJ viewed the significance of the relationship between the parties as an issue of crucial importance, adding that 'influence may be … powerful between close relatives where one may be in a dominant position vis-à-vis the other'.[116]

In a similar vein, Donaldson MR, observed that

> The relationship of the persuader to the patient may be of crucial importance. The influence of parents on their children or of one spouse on the other can be, but is by no means necessarily, much stronger that would be the case in other relationships. Persuasion based upon religious belief can also be much more compelling and the fact that arguments based upon religious beliefs are being deployed by someone in a very close relationship with the patient will give them added force.[117]

It is, therefore, evident that Butler-Sloss LJ and Donaldson MR clearly recognised that certain classes of relationships 'more readily lend themselves to overbearing the patient's independent will than others do',[118] although they stopped short of recognising the equitable presumption. In *Re T*, the mother-daughter relationship, coupled with T's mother's fervent belief in the sin of blood transfusion, was, inter alia, of significant importance to the finding of undue influence. However, whilst, the Court recognised that the relationship between the parties was significant, it was also explained that medical undue influence is a question of fact and degree. There is no clear dividing line separating mere influence from undue influence, as this question is determined on a case-by-case basis.

On this issue, Butler-Sloss LJ, adopting the words of Hannen P in the probate case of *Wingrove v Wingrove*[119] discussed earlier, stated that 'the degree of pressure to turn persuasion or appeals to affection into undue influence may … be very little'.[120]

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[115] Ibid.
[116] Ibid 120 (Butler-Sloss LJ).
[117] Ibid 113–14 (Donaldson MR).
[118] *CRM* (n 131) [20] (Hale LJ); *Re T* (n 6) 116 (Donaldson MR).
[119] 11 P.D. 81, 82–83 cited in *Re T*, 120 (Butler-Sloss LJ).
[120] Ibid.

Considering the facts of the present case, Butler-Sloss LJ explained that T's exposure to her mother's religious beliefs in childhood, her grave medical condition, and the administration of strong narcotic pain relief was, given these circumstances, likely to considerably enhance the pressure from her mother.[121] Therefore, due to T's weakened condition, minimal pressure was sufficient to constitute undue influence. Similarly, Lord Donaldson MR observed that the strength of will of the patient is a pertinent consideration when ascertaining whether influence is undue. His Lordship added that 'one who is very tired, in pain or depressed will be much less able to resist having his will overborne'.[122] Thus, whether undue influence is present on the facts is closely tied to the health of the person, and the ability to resist undue influence clearly diminishes if they are in a weakened state of health.

Therefore, *Re T* served to highlight important factors concerning medical undue influence. Importantly, *Re T* clearly established that the equitable presumption will not apply. Furthermore, the Court characterised undue influence as a type of overbearing influence that 'saps the will and destroys the volition',[123] and concluded that when considering this issue, the relationship of the parties is significant, as 'some relationships more readily lend themselves to overbearing the patient's will than others do'.[124] Finally, the health of the patient is a relevant consideration, as one whose health is compromised will be more susceptible to undue influence. However, as explained above, whilst *Re T* provided some clarity concerning the operation of undue influence in this area of law in the UK, within Australian — and South Australian — borders there is a lack of binding authority

[121] Ibid.
[122] Ibid 113 (Donaldson MR).
[123] Ibid 120 (Butler-Sloss LJ).
[124] Ibid 116 (Donaldson MR).

concerning medical undue influence.[125] To date, *Re Fay* is the only case where an Australian court tacitly affirmed *Re T*.

Judicial Consideration of Re T in Australia: Application of a Local Health District; Re a Patient Fay [2016] NSWSC 624

[15.700] Undue influence was but one of several issues for consideration before Sackar J in *Re Fay*. The primary issue before the Court was whether Fay lacked the requisite capacity to consent to medical treatment at common law.[126] Therefore, the majority of his Honour's judgment was dedicated to this issue and the discussion on undue influence was correspondingly minor. Despite this limitation, Sackar J alluded to some factors that were influential in determining the existence of undue influence in a consent to medical treatment. In *Re Fay*, the treatment decision which the Hospital sought to impugn was the refusal to terminate a pregnancy. This treatment was recommended by Fay's treating specialists as she was 'at a significant risk of permanent cerebral damage and possible death'[127] if the pregnancy were to continue. The Hospital initially sought an Application for Special Treatment from the New South Wales Civil and Administrative Tribunal ('NCAT'), declaring that the Hospital could intervene notwithstanding Fay's refusal, which was dismissed.[128] The Hospital appealed NCAT's finding and applied to the New South Wales Supreme Court for an order that leave be granted to conduct a rehearing and call fresh evidence.[129] Sackar J approved the application for leave and ordered a bedside hearing take place immediately. Relevant to the issue of undue influence, Sackar J

[125] See especially *CRM* (n 131). *CRM* affirmed the principles established in *Re T*; however, the Court of Appeal determined that no undue influence was exercised in this case. Significant to this finding was the health and idiosyncratic characteristics of the party alleged to have been unduly influenced: see *CRM* (n 131)[19] (Phillips MR, Mummery and Hale LJJ).
[126] For further discussion on the issue of capacity, see *Re Fay* (n 121) [34]–[38]. Sackar J also considered whether the NCAT erred in finding that Fay had capacity to consent and whether their failure to provide reasons for the decision was an error of law: see paras [87]–[90].
[127] *Re Fay* (n 121) [4].
[128] Ibid [13]. For further discussion on the procedural history, see paras [8]–[19].
[129] Ibid [19].

considered whether the influence of Fay's mother on Fay to refuse consent to terminate her pregnancy was, in light of the surrounding circumstances, undue influence, to which his Honour concluded yes.

At the time of the hearing, Fay was 22 weeks pregnant with her second child. She was 19 years old, had little education, suffered from an intellectual disability and was living with her mother, step-father and her four-year-old son. She was admitted to hospital where she was diagnosed as suffering from a placental haematoma, progressive renal failure and hypertension, and, despite being administered medication to treat her conditions, her symptoms remained uncontrolled. Consequently, Fay was transferred to the Hospital's intensive care unit, where termination of her pregnancy was advised as it was posing a significant threat to her health and life. She was further advised that if she consented to medical intervention — that is, ending her pregnancy — the foetus would not survive birth.[130]

Fay refused to end her pregnancy and her mother 'was vehemently opposed to any form of intervention except in what might be described as dire circumstances'.[131] Despite this limited refusal, Fay signed a form consenting to the termination of her pregnancy if specific severe medical conditions presented.[132] The treating medical team was, however, of the view that intervention needed to occur immediately as waiting for one of these events to manifest was dangerous. Fay's relationship with her mother was a significant issue before the Court, and Sackar J closely considered the influential impact she had on Fay's decision to refuse medical intervention.

[130] Ibid [58]–[76].
[131] Ibid [50].
[132] Ibid [5].

The Hospital adduced evidence indicating that, whilst Fay was admitted in hospital, 'Fay's mother was the interface between her and the medical practitioners,'[133] making it difficult for the treating medical team to ascertain what Fay actually wanted. During the bedside hearing, Sacker J noted that Fay made very little contribution to the proceedings and appeared to be sleeping, although she was not. He observed that her mother was 'exceedingly voluble', but qualified this by adding that she was well intentioned.[134] Furthermore, his Honour noted that at all times during the hearing she 'purported to speak on behalf of Fay indicating that Fay had strongly held views as well opposing intervention and that Fay understood all of the relevant risks that might manifest'.[135] Additionally, the expert psychiatrist, who examined Fay, concluded that 'Fay's mother had played a very significant if not dominant role in Fay's upbringing and ongoing care',[136] to which his Honour agreed.

When providing an overview of the law in relation to consent to medical treatment, Sackar J mistakenly considered undue influence as a question of capacity.[137] Despite the failure to explicitly indicate that capacity and undue influence are separate principles, his Honour, however, correctly identified that questions of undue influence focus on the role of a third party in the decision-making process.[138] The only authority relied on regarding undue influence was *Re T*, where his Honour remarked that the vital question before the Court in determining undue influence was whether the patient's ability to consent to the treatment was undermined due to the overbearing influence of a third party.[139] When considering the vital threshold issue regarding influence, Sackar J cited Donaldson MR in

[133] Ibid [46].
[134] Ibid [50].
[135] Ibid.
[136] Ibid [51].
[137] Ibid [34]–[42].
[138] Ibid [40].
[139] Ibid (Sackar J), citing Lord Donaldson MR in *Re T*, 113.

Re T, stating that 'a person [is] entitled to receive advice and assistance from others in reaching a decision especially from family members. Even strong opinions that are designed to persuade a person to make a particular decision will not be objectionable "so long as it did not overbear the independence of the patient's decision"'.[140] Therefore, it is evident that Sacker J did not outwardly reject the important role families play in the decision making process — an important fact in the present case — but recognised that there is a limit to this, with the pivotal issue being that the decision must reflect the patient's free and independent will. His Honour clarified his reasoning, explaining that whether influence traversed what was acceptable in the circumstance is a relative concept and a question of fact and degree, noting that influence 'could be subtle, insidious and pervasive … [and] most potent when exercised between close relatives'.[141]

Taking into consideration the surrounding factual circumstances including Fay's relationship with her mother, her disability, limited education, vulnerability and sustained unwillingness to engage with medical staff, Sackar J found that Fay's refusal of treatment was vitiated due to undue influence.[142] His Honour commented that 'the influence of [Fay's] mother was a most significant factor',[143] characterising her attitude as 'somewhat domineering [and] overly protective'.[144] He continued, observing that 'Fay's mother had played a very significant if not dominant role in Fay's upbringing and ongoing care,'[145] adding that Fay 'neither had the strength nor the ability to contest the will of her mother'.[146] Thus, the culmination of these factors supported the conclusion that the decision was not freely made and was the product of undue influence.

[140] Ibid.
[141] *Re Fay* (n 121) [40]–[42] (Sackar J), citing Butler-Sloss LJ in *Re T* (n 6) 120.
[142] Ibid [85]. He also found that Fay did not have capacity to give a valid refusal of consent.
[143] Ibid [82].
[144] Ibid [52].
[145] Ibid [51].
[146] Ibid [85].

Discussion on *Re Fay*

[15.800] *Re Fay* is an extraordinary case as it presents an overt example of undue influence. It is evident that undue influence was occurring in plain sight and the treatment team identified that the behaviour of Fay's mother posed a significant threat to the independence of Fay's decision. Often, undue influence is a behaviour that occurs covertly and behind closed doors. Its existence manifests after the courts carefully scrutinise the facts surrounding the impugned decision and the idiosyncratic characteristics of the influenced party.[147] The fact that undue influence is difficult to identify is one of the key characteristics that poses a significant barrier regarding its appropriateness as a statutory safeguard for a voluntary request for VAD. When applied in the context of VAD, undue influence is highly likely to be less overt and done away from the clinical environment — mainly because of the nature of the request, and to explicitly task doctors with identifying and reporting it is imposing a significant burden on them. In *Re Fay*, the situation was unique, there was a particularly vulnerable patient with limited capacity and an overwhelming intervener, therefore the observation and identification of the undue influence was unusually easy. Although Sacker J did not provide a list of factors relevant to undue influence in this sphere, important points can be taken from this decision.

First, his Honour recognised the importance families play in the decision-making process. Sackar J adopted Donaldson MR's reasoning in *Re T* on this issue, highlighting that a patient is 'entitled to receive advice and assistance from others in reaching a decision especially from family members''[148] The important issue in *Re Fay* was not the fact that Fay had likely consulted with her mother regarding her treatment, but rather that her

[147] See, eg, *Johnson* (n 31).
[148] *Re Fay* (n 121) [42] (Sackar J), citing Donaldson MR in *Re T* (n 6) 113.

mother was overly dominating and controlling and it could not be concluded that the refusal of intervention was indeed Fay's decision. Thus, this decision cannot be viewed as the Court placing an unfair caveat on the importance of families in the decision-making process, but rightfully recognises that limits are placed on this. Furthermore, Sackar J alluded to the significance of the patient's health regarding questions of undue influence. It was observed that the ability to resist undue influence is likely to be significantly impeded if the patient is in a weakened state due to poor health, suggesting that undue influence is a fluid concept, entirely dependent upon the surrounding factual circumstances.

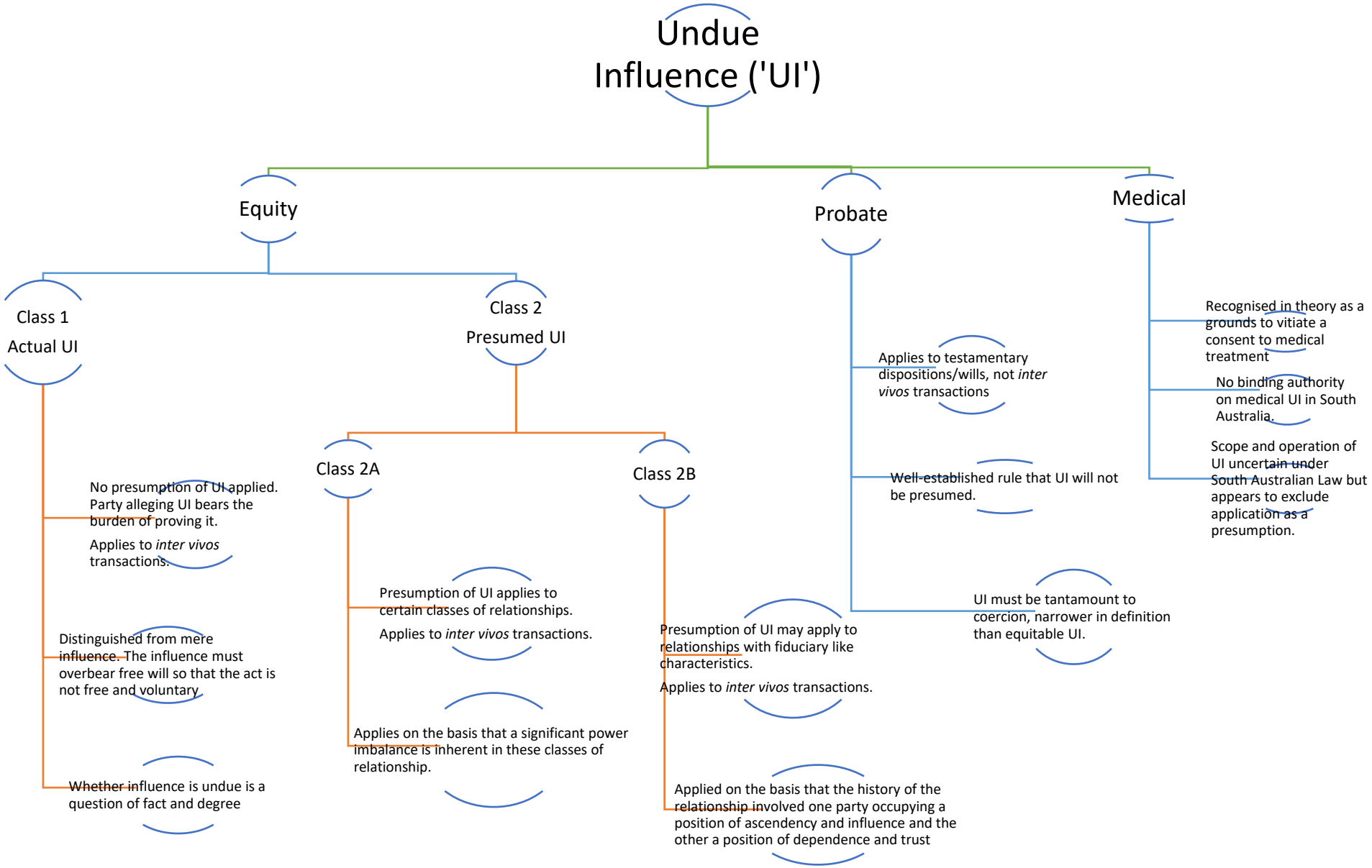
It is not possible to engage in further discussion on undue influence in the area of consent to medical treatment, as the majority of the judgment was confined to the issue of capacity. Sackar J stopped short of explaining what medical undue influence was in full, or clarifying important questions concerning the application of a presumption of undue influence in this area. Therefore, the law remains uncertain. Furthermore, given that the judgment in *Re Fay* was delivered by a single justice of the Supreme Court of New South Wales, it is only persuasive in South Australia. Binding legal authority concerning medical undue influence in South Australia is non-existent. Despite these limitations, *Re Fay* serves as anecdotal evidence of the doctrine of undue influence being applied by an Australian court and key points can be taken away from *Re Fay*. Undue influence is difficult to identify, it depends upon the nature of the individual, their idiosyncratic characteristics, such as their health and intellect, and the overall surrounding circumstances. However, this does not help to clarify the myriad issues that arise concerning screening for undue influence in a request for VAD. This instead has the effect of adding another layer of ambiguity. In the absence of clarification of key features of undue influence, it is likely an ill-suited protection of a voluntary decision for VAD.

Summary

[15.900] It was explained in the introduction to Part 3 that the purpose of this chapter was twofold: first, it aimed to describe what undue influence is, with a view to identifying its nature and what it seeks to protect; this would inform the second goal, which was to demonstrate that undue influence is not a straightforward term but is instead burdened by a significant judicial history. For clarity, key features of undue influence in equity, probate and consent to medical treatment have been provided in Diagram 2 below.

It is clear that undue influence is dependent upon the specific issues in dispute. In each of the separate areas considered above, significant differences are evident regarding the application of the doctrine. The predominant difference with these separate incarnations of the doctrine of undue influence is whether an evidential presumption can be argued, with the courts only recognising this in equity so far. Furthermore, there has been sustained reluctance to attribute a precise definition to undue influence. Whilst the authorities show a general consistency in describing key features of it, such as it being a form of external pressure or overbearing influence that vitiates free will and volition, the judicial discussion far from provides a clear picture on the doctrine of undue influence. Instead, the cases show that undue influence is convoluted, ambiguous, highly fact-specific and a question of degree in all cases. It requires an intimate and intricate examination of the relevant circumstances surrounding the issue the court has been called upon to consider. Furthermore, the courts have applied significantly different rules in each jurisdiction, rendering clear identification of a single doctrine of undue influence a difficult task, although the underlying principle undue influence aims to protect is the voluntariness of decision-making. Despite the unifying goal of protecting individual

choice, undue influence is clearly not a straightforward term. To include it as a statutory safeguard is flawed and places an unreasonable burden on medical practitioners and members of the general public who may not equipped to identify ordinary influence let alone undue influence, which undermines its ability to provide meaningful protection of voluntary choice. Given the gravity of VAD, the consequence of failing to appropriately protect voluntary choice is severe as it can result in a non-voluntary death, for which the law cannot provide recourse.


Undue Influence ('UI')
Equity
Probate
Medical
Class 1
Actual UI
Class 2
Presumed UI
Class 2A
Class 2B
No presumption of UI applied. Party alleging UI bears the burden of proving it.
Applies to *inter vivos* transactions.
Distinguished from mere influence. The influence must overbear free will so that the act is not free and voluntary
Whether influence is undue is a question of fact and degree
Presumption of UI applies to certain classes of relationships.
Applies to *inter vivos* transactions.
Applies on the basis that a significant power imbalance is inherent in these classes of relationship.
Presumption of UI may apply to relationships with fiduciary like characteristics.
Applies to *inter vivos* transactions.
Applied on the basis that the history of the relationship involved one party occupying a position of ascendency and influence and the other a position of dependence and trust
Applies to testamentary dispositions/wills, not *inter vivos* transactions
Well-established rule that UI will not be presumed.
UI must be tantamount to coercion, narrower in definition than equitable UI.
Recognised in theory as a grounds to vitiate a consent to medical treatment
No binding authority on medical UI in South Australia.
Scope and operation of UI uncertain under South Australian Law but appears to exclude application as a presumption.

Chapter 16: Issues with undue influence as a statutory safeguard in proposed VAD legislation

Introduction

[16.10] The critical analysis of undue influence provided in Chapter 15 demonstrated that it is a term burdened by a rich judicial history, and, as a consequence of its history, it has changed form. It is a creation of equity, developed to supplement common law duress. Equity, with its focus on conscience and protection against infinite varieties of fraud, developed two categories of presumed undue influence — Class 2A and Class 2B — as a means to protect weaker parties in selected classes of relationships by shifting the burden of proof to the stronger party to establish that the act was free and voluntary. As undue influence expanded beyond the confines of equity, the probate courts adapted it to fit that area of law, rejecting the equitable presumption, thus giving it a distinct meaning in probate. Furthermore, its expansion into the area of medical law has resulted in even greater uncertainty concerning the meaning of undue influence, as there is currently no binding precedent from the High Court of Australia or a court of South Australian jurisdiction. The overarching theme from Chapter 15 is that the meaning of undue influence is nuanced and dependent upon the area of law in which it is being applied. Additionally, it does not exist as a term in the ordinary English lexicon and the courts have been steadfast in demarcating mere influence, familiar to the English language, from undue influence. Yet this vital distinction was not clarified in any of the VAD bills where protection against undue influence was included as a key statutory safeguard, and therefore there is significant uncertainty and ambiguity concerning the meaning of this term.

Of the South Australian bills where screening for undue influence formed part of the framework of safeguards,[1] undue influence was never defined. Undue influence has not been given a statutory definition in any of these bills. As a legal doctrine, it is applied divergently in equity, probate and in the common law. As a consequence of these issues, several pertinent concerns arise regarding the suitability of undue influence as a proposed statutory safeguard in VAD legislation. The focus of this chapter is to further elucidate the issues that arise as a result of the lack of a clear definition of undue influence.[2] The paramount considerations are that there is considerable ambiguity surrounding the meaning of undue influence and, when combined with the challenges in ascertaining parliamentary intention in relation to its use in this context, drain the protection of meaning. It is asserted that even if parliament were to attempt to devise a screening test or guidelines for undue influence, given its application in equity and law, a test based on undue influence may be overly technical, burdensome and impractical, thus calling for a comprehensive re-thinking of this important statutory protection that aims to protect the vital principle of voluntary choice.

Ambiguity concerning the definition of undue influence

[16.20] The core criticism of undue influence as a proposed statutory safeguard in VAD legislation is that the legislature failed to define or clarify what undue influence means. This oversight is likely to render it meaningless as a protection and may expose doctors to unnecessary risk of disciplinary action. An overview of past VAD bills tabled in South

[1] These are outlined in Table 5.

[2] The meaning of a legislative term is a matter of statutory interpretation and whether a legislative term is given an ordinary meaning or a technical meaning is a question of law to be determined by the courts: see *Collector of Customs v Pozzolanic* (1993) 43 FCR 280. It is not the focus of this thesis to ascertain, through a statutory interpretation lens, how the courts will attempt to resolve the ambiguity concerning undue influence. The focus here was to highlight issues with undue influence being relied on as a statutory safeguard in VAD legislation.

Australia where undue influence was included as a proposed statutory safeguard was provided in Table 5. For clarity, key information from Table 5 will be reproduced here.

The requirement for medical practitioners and witnesses to assess for undue influence in a request first appeared in 2010, where the Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill ('ELA Bill') added this as a safeguard. This provision required two medical practitioners to assess for undue influence in a request for VAD. If they suspected that the person making the request was acting under any form of undue influence, then referral to a psychiatrist was mandatory.[3] This initial use of 'undue influence' in the ELA Bill was not accompanied by any definition within the Bill or raised during the parliamentary debates and secondary materials. Without this necessary explication, it risks becoming a meaningless phrase that signifies nothing.

The ELA Bill required the request practitioner and a witness to make reasonable enquiries to form the opinion that the person was not acting under undue influence.[4] The majority of VAD bills tabled after 2010 included near identical provisions to screen for undue influence in a request, although some variation in terminology was evident. These differences predominantly centred on the requirement, or not, to form a reasonable suspicion that the person was acting under undue influence.[5] For instance, the Death with Dignity Bill 2016 (SA) ('DWD Bill') stated that if the medical practitioner performing the preliminary assessment reasonably suspected that 'the person is acting under any form of … undue influence in relation to their request for voluntary euthanasia [then] the medical practitioner must refer the person to a psychiatrist for examination and

[3] Section 35(3)(d)(iii), 35(3)(d)(vi).
[4] Ibid s 35(6)(c).
[5] See Table 5.

assessment'.[6] The DWD Bill also required a second medical practitioner to screen for undue influence when performing their examination and assessment. However, the second medical practitioner was under no obligation to form a *reasonable suspicion* but rather had to '*be of the opinion*'[7] that the person was acting under undue influence. It is uncertain why the legislature adopted different terminology for these separate assessments, and this does not appear as a point of discussion in Hansard. The DWD Bill did not clarify what constitutes a reasonable suspicion or list any factors that would facilitate the formation of a 'reasonable suspicion'. The fact that the suspicion had to be reasonable is an issue itself, as it raises questions concerning what is considered reasonable, but this issue will not be examined further as consideration of it is beyond the scope of this thesis. However, without even addressing any potential issues with 'undue influence', the fact that referral to a psychiatrist was predicated on forming a reasonable suspicion was itself precarious. Regardless of any semantic difference that may exist regarding the adoption of different terminology, it is evident that both medical practitioners were required to justify their reason for referral.

The DWD Bill further required the medical practitioner to assess whether the person was '*acting under any form*' of undue influence.[8] The inclusion of the words '*acting under any form*' likely suggests that there is more than one form of undue influence. This is not untrue, as discussed in Chapter 15. However, to require the medical practitioner performing the preliminary medical examination to form a reasonable suspicion that the person is acting *under any form of undue influence* is exceptionally burdensome and bordering on impossible, as it would require the medical practitioner to have expert knowledge on the various applications of undue influence across jurisdictions.

[6] Section 11(2)(c); see also 12(2)(c).
[7] Death with Dignity Bill 2016 (SA) s 12(2)(c) ('DWD Bill') (own emphasis).
[8] Ibid s 11(2)(c).

Medical practitioners are clinicians, experts in medicine, not law. Whilst the law underlies fundamental aspects of medical practice and requires medical practitioners to have an understanding of general legal principles, the fact that the DWD Bill required medical practitioners to assess whether the person was acting *under any form of undue influence* is traversing into territory which is highly likely to exceed their non-expert understanding of the law. It is unreasonable to place this obligation on them. Furthermore, to actually form a reasonable suspicion depends upon knowing what undue influence is. In other words, if the medical practitioner does not understand what undue influence is, then this will directly impede their ability to form a reasonable suspicion of its existence as required under the proposed legislation. A similar concern also applies to the requirement to *be of the opinion*.[9] It is not possible to form an opinion on something that has not been defined or clarified, and clearly exceeds the knowledge base of persons not expert in the law of undue influence.

Additionally, the DWD Bill positioned medical practitioners as predominantly sole adjudicators on questions of undue influence. The psychiatric referral provisions were only discretionary. It cannot be said with any certainty whether psychiatrists are in a better position to examine for undue influence in a request, and this issue will not be considered here. The fact that the DWD Bill required medical practitioners in general to be adjudicators of a highly technical legal term, without providing any clarity or guidance regarding what it is, is confounding. This in turn undermines the purpose of establishing a broad framework of protections for a voluntary decision.[10] The medical practitioners who were charged with the duty to screen for any form of undue influence are unlikely to

[9] Ibid s 12(2)(c).
[10] See Chapters 4 and 5 for further discussion on psychiatric referral under selected South Australian VAD bills.

be in a position to fulfil this obligation due to the uncertainty and ambiguity surrounding the construction of the term. The likely consequence of this is that the medical practitioners will either overlook key facts that would give rise to a reasonable suspicion that undue influence was being exerted or practice defensive medicine by over-referring to psychiatrists.

Regarding the latter scenario, this would have a burdensome impact on the individual who is already frail and infirm. The eligibility requirements under the DWD Bill state that the person must be diagnosed with a terminal medical condition which causes intolerable suffering and, as a consequence of their medical condition, their death has become inevitable.[11] The fact that they cannot make a request until they have reached this advanced stage of their illness is likely to render referral to another expert a significant imposition. Furthermore, this is likely to delay their request being approved as it is dependent upon review by another medical expert. The corollary of these factors are likely to have an unjust impact on the individual. It could unnecessarily prolong the individual's suffering, or they could lose capacity in the interim due to a rapid decline in their health or simply act as a deterrent from progressing with their request for VAD.

However, the concerns in relation to the former scenario are much more deleterious. In this circumstance, if undue influence is unintentionally overlooked and the request for VAD has been approved and VAD is administered, then no remedy can be provided to compensate for this error. Death is final. Therefore, as a consequence of this definitional ambiguity, the undue influence provisions are unlikely to provide any meaningful protection against undue influence, but instead expose the medical practitioner and patient to unacceptable risk. The risks that may arise will be examined in the next chapter.

[11] DWD Bill ss 9(2)(b)(i), 9(c).

Legalising VAD is a significant step to take, as it permits medical practitioners to prematurely end a patient's life by either directly administering lethal substances or by giving the patient access to lethal substances to end their own life. These acts directly contradict firmly entrenched societal norms concerning the value attributed to all human life and the state's duty to uphold this well-entrenched principle by prosecuting those who end it or assist others to do so. Given that the aim of VAD is to cause death, the safeguards in place to ensure that the person accessing VAD has given free and voluntary consent must be clear and unequivocal. As it stands under the identified Bills, serious issues arise concerning the suitability of undue influence as a term of choice to meet this desired end.

Similar issues also arise concerning the obligation placed on witnesses to certify that the person did not appear to be acting under undue influence, which was a requirement of several of the more recent VAD bills. An outline of these provisions can be found in Table 5 of this thesis.[12] The obligation placed on witnesses was largely consistent amongst these bills, with only minor changes in terminology evident.[13] Similar issues also arise regarding the obligation placed on witnesses to screen for undue influence, which, in turn, undermine the efficacy of the statutory safeguards that aim to protect individuals against it.

For instance, under the DWD Bill, two witnesses were required to certify on the voluntary euthanasia request form that they were 'of the opinion that the eligible person was not

[12] See Chapter 5 for discussion of the witness provisions.
[13] See, eg, DWD Bill s 14(1)(c)(v); cf Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA) s 35(6)(c).

acting under any form of … undue influence'.[14] The DWD Bill clarified the eligibility requirements concerning who could act as a valid witness, with a view to restrict persons whose objectivity may be compromised.[15] The restrictions incorporated in the DWD Bill explicitly excluded the following individuals from acting as a witness:

- medical practitioners who examined or assessed the person making the request;[16]
- beneficiaries with a direct or indirect interest in the estate of the person making the request;[17] and
- owner/operators and employees of a hospital or institution where the person resides

Despite these caveats, the DWD Bill permitted relatives, acquaintances and friends to act as a witness as long as they satisfied the conditions listed.[18] However, this was only a discretionary requirement; as a consequence, the DWD Bill permitted any person unknown to the patient to perform this significant task.[19] As undue influence was not defined in any of the VAD bills, similar issues arise concerning the uncertainty and ambiguity of undue influence. The DWD Bill required two witnesses to certify that they were of the opinion that the person was '*not acting under any form of undue influence*'.[20] The position adopted here is that undue influence does not have an ordinary meaning as it is a legal term. Moreover, the meaning of undue influence was never clarified in the DWD Bill. If this had been done, it would have provided essential insight into whether the legislature intended to displace its legal meaning. The way this safeguard has been drafted

[14] DWD Bill s 14(1)(c)(v).
[15] Ibid s 14(2).
[16] Ibid s 14(2)(a).
[17] Ibid s 14(2)(b).
[18] Ibid s 14(1)(a).
[19] Section 14(1)(a) of the DWD Bill states that the presentation of the voluntary euthanasia request form must be done before 'two witnesses (who *may*, subject to subsection (2), be related to, or known by, the eligible person to whom the request relates).' The inclusion of the word may, as opposed to shall, indicates that it this a discretionary requirement see *Acts Interpretation Act 1915* (SA) s 34.
[20] DWD Bill s 14(1)(c)(v) (own emphasis).

presupposes that doctors and witnesses have expertise on undue influence. Therefore, to oblige witnesses, who are likely to be members of the general public, to screen for undue influence, a technical legal term that is neither defined nor clarified in the Bill, is an exceptionally onerous obligation. In a practical setting, any member of the general public, as long as they satisfy the inclusionary/exclusionary requirements, could be called upon to certify that the person did not appear to be acting under any form of undue influence. The risk that may eventuate is that this safeguard will be reduced to a box-checking requirement because of the uncertainty surrounding what it is and how to satisfy this obligation, thus undermining the value of this statutory protection. Consequently, this is unlikely to provide any meaningful protection of a voluntary decision.

VAD is a serious matter. There is no scope for ambiguity and uncertainty in the statutory safeguards that seek to ensure the person requesting VAD is doing so freely and voluntarily. The inclusion and repetition of the word 'voluntary' under the objects and principles of the DWD Bill are indicative of parliament's intention to ensure that a request for VAD was indeed voluntary and that this is not compromised.[21] This suggests that strong framework of statutory safeguards would be mandated to ensure that this core principle can be upheld. As it stands, serious flaws exist with the safeguards which aim to protect against undue influence, thus vitiating the significance given to voluntariness under the DWD Bill, contrary to its objects and principles. It appears that the drafting of the VAD bills overlooks the rich judicial history of undue influence in our legal system. It is not a straightforward term, but is a term burdened by its history.

[21] Ibid ss 6, 7.

[16.30] It is clear that the lack of a clear definition of undue influence imposes an onerous obligation on medical practitioners and witnesses. There is no static, singular definition of undue influence. Its application differs contextually. It is unclear whether the legislature unintentionally overlooked the complexity of undue influence or intentionally decided not to address it at that point in time for the five VAD bills introduced from 2010–2016.[22]

In the introductory chapter to this thesis, it was noted that the *Voluntary Assisted Dying Act 2021* (SA) ('*VAD Act* (SA)'), which was passed on 24 June 2021, omitted protection against undue influence as a core statutory safeguard, instead enunciating that a key principle of the *VAD Act* (SA) was that every individual adult has the right to choose freely, free from the undue influence of others.[23] Yet despite this, screening for undue influence was excluded and the corresponding obligation on medical practitioners was to ensure that the person requesting VAD was acting free from coercion.[24] No definition of coercion was provided in the Act itself. This is equivocal to say the least. Coercion is different from undue influence — unless the testamentary definition of undue influence is applied — and the inclusion of undue influence as a principle of the Act reflects a misunderstanding with regard to the chosen terminology in the *VAD Act* (SA). It is uncertain at this early stage of the implementation process how coercion will be defined, if at all, and whether

[22] The legislature could, if VAD became lawful in South Australia and undue influence were retained as a safeguard in its previous form, pass regulations or delegated legislation under the law to clarify the ambiguity surrounding undue influence. This is purely speculative and there is a strong argument that this should perhaps be clarified in the legislative instrument itself as it could be beneficial in gaining the majority support required to become law.
[23] Section 8(1)(k).
[24] See Chapter 1.

further clarity will be provided reconciling this clear terminological incongruity by way of regulations passed under the law.[25] If screening for undue influence were to be included in any subsequent delegated legislation as a consequence of its existence in s 8(1)(k) of the *VAD Act* (SA), then clarity concerning its scope and operation is essential. However, given the substantial legal history of undue influence, there is a risk that, even with such clarity included in the drafting, this may still pose an unreasonable burden on medical practitioners and witnesses.

The legislature can choose to displace the equitable and common law definitions of undue influence, supplanting it with a statutory definition. The position adopted here is that undue influence does not have an ordinary meaning; it is a legal term; for example, there is no definition of that phrase in the *Macquarie Dictionary*.[26] The fact that 'influence' was preceded by the specific adjective 'undue' instead of 'excessive',[27] for example, can be viewed as support for this being a legal term. The case law on undue influence can, however, be utilised to develop an appropriate definition of, and screening tool for, undue influence to redress the uncertainty regarding this term.

In Chapter 15, it was explained that the general nature of undue influence was to protect free will and agency by recognising that overbearing persuasion and influence could vitiate a voluntary decision.[28] Therefore, undue influence is considered to be a form of overbearing external influence, persuasion, or coercion, not amounting to threats of or

[25] *Voluntary Assisted Dying Act 2021* (SA) s 130.
[26] Undue influence is not recognised term in Australian English: see *Macquarie Dictionary* (online, 14 April 2021) 'undue influence'.
[27] Undue was defined in the Macquarie dictionary as excessive: see *Macquarie Dictionary* (online, 15 April 2021) 'undue'.
[28] See, eg, *Thorne v Kennedy* (2017) 350 ALR 1, 11 ('*Thorne*'); *Johnson v Buttress* (1936) 56 CLR 113, 134 ('*Johnson*'); *Union Fidelity Trustee Co of Australia v Gibson* [1971] VR 573 ('*Union Fidelity Trustee*'); *Hall v Hall* (1868) LR 1 P & D 481, 482 ('*Hall*'); *Re T (Adult: Refusal of Medical Treatment*) Fam 95, 113 ('*Re T*').

actual violence, that vitiates voluntariness and free will. It is well established that *mere* influence is distinct from *undue* influence and what is considered undue is a question of fact and degree.[29] These general features of undue influence are largely evident in all incarnations of the doctrine. Thus, undue influence could be defined as 'a form of overbearing influence, persuasion or coercion, that does not amount to threats of, or actual violence, but extends beyond mere influence, exercised by one person on another that vitiates free and voluntary will in another'. This constructed definition, however, does little to clarify important threshold questions concerning when mere influence becomes overbearing to the extent that it vitiates free will, and this definition would need to be supplemented with guidelines to facilitate determining questions of undue influence. In the alternative, the legislature could choose not to derive a definition of undue influence from case law, and instead adopt an ordinary meaning.

The *Macquarie Dictionary* includes definitions of both 'undue' and 'influence'. There are two relevant definitions of 'undue' provided, defining it as 'unwarranted; excessive' [or] too great'[30] or 'not proper, fitting or right; [or] unjustified.'[31] 'Influence' as a noun is defined as an 'invisible action exerted by one … person on another.'[32] In its verb form, it is defined as 'to exercise influence on; [or to] modify, affect or sway'[33] or 'to move or impel to, or to do, something.'[34] Therefore, utilising the ordinary meanings of these terms, undue influence could be defined a 'a form of unwarranted, excessive or unjustified invisible action exerted by one person on another to move or impel them to do something (ie make a request for VAD).'

[29] Ibid.
[30] *Macquarie Dictionary* (online, 15 April 2021) 'undue' (def 1).
[31] Ibid (def 2).
[32] Ibid (noun, def 1).
[33] Ibid (verb, def 5).
[34] Ibid (verb, def 6).

It is evident that there are differences between the legal doctrine definition and the definition constructed from the ordinary definitions of the individual words ('the ordinary definition'). These example definitions are not intended to be exhaustive but serve to illustrate how undue influence could be defined. Whether the constructed legal, ordinary or some other definition of undue influence will be adopted is ultimately a decision for the legislature. However, it is obvious that neither the legal or ordinary definitions attribute sufficient meaning to undue influence or how to screen for it. Thus, any definition would need to be supplemented by a list of factors that would facilitate undertaking this examination. This has the potential to become an arduous task for medical practitioners and witnesses alike.

Factors that would facilitate screening for, or identifying, undue influence could be derived from the case law on undue influence. In all versions of undue influence, the courts have discussed elements that were influential in finding undue influence. For instance, in *Re T*, Donaldson MR considered the strength of will of the individual patient and the relationship between the persuader and the influencing party as key facts.[35] On the former point, his Lordship observed that persons who were very tired, in pain or depressed are less likely to be able to resist undue influence as opposed to those of good health.[36] This is an important factor in the context of VAD as most patients would satisfy the conditions identified by Donaldson MR. Regarding the latter issue, his Lordship viewed relationships between spouses and parents and children as likely to have an important bearing on questions of influence. In a similar vein, Edelman J in *Anderson v*

[35] *Re T* (n 28) 113 (Donaldson MR).
[36] See also *Wingrove v Wingrove* (1885) 11 P.D. 81, 82–83 (Hannen P) ('*Wingrove*').

McPherson (No 2)[37] also perceived the relationship between the parties as a matter of importance. His Honour remarked that relationships 'involving dominion and ascendancy by one person over the will of the other, and correlative dependence by the other'[38] as important to establishing undue influence. It is evident that Edelman J's observation is broader than Donaldson MR's as it extends beyond relationships of kinship to encompass any form of association. Therefore, any potential list of factors developed to assist in identifying undue influence would need to highlight the impact relationships between the patient and people in their familial and social circles can have on undue influence.

In *Allcard v Skinner,* Kekewich J also discussed the importance of the individual's circumstances explaining that 'influence, however natural and however right, shall not be unduly exercised, that is, shall be exercised only in due proportion to the surrounding circumstances and the strength of the person submitted to it'.[39] Similarly, in *Wingrove v Wingrove*,[40] Hannen P noted how nuanced undue influence can be, emphasising that it is a question of fact and degree. Drawing on the significance of the individual's broader social circumstances, the President explained that

> A person in the last days or hours of life may have become so weak and feeble, that very little pressure will be sufficient to bring the desired result, and it may even be, that the mere talking to him at that stage of illness and pressing something upon him may so fatigue the brain, that the sick person may be induced, for quietness' sake, to do anything, though not actual violence.[41]

Therefore, it is evident that determining questions of undue influence requires careful scrutiny of the person's personal circumstances, navigating their past and present which is likely to require a person with expertise not only on undue influence, but

[37] [2012] WASC 19.
[38] *Anderson v McPherson (no 2)* [2012] WASC 19, [247] (Edelman J) (emphasis added).
[39] *Allcard v Skinner* (1887) 36 Ch. D 145, 157-58 (Kekewich J) (emphasis added).
[40] (1885) 11 Pr. D. 81.
[41] *Wingrove* (n 36) 82-3 (Hannen P).

communication and interviewing as well. On a similar note, Gillard J in *Union Fidelity Trustee Co of Australia v Gibson*,[42] provided a broader list of considerations that would render someone susceptible to undue influence. It was observed that 'the standard of intelligence and education, and the character and personality [of the individual and] the age, state of health, blood relationship'[43] to the person exercising the influence are pivotal considerations in the inquiry. Several seminal cases have also considered these factors as pertinent to undue influence and, to avoid repetition, they will not be discussed.[44]

Therefore, important factors can be derived from the cases on undue influence. These factors could be used to facilitate identifying undue influence and attribute further meaning to its definition. They include the following guidelines:

1. Assessment of undue influence requires careful consideration of the person's broader social circumstances;
2. Undue influence can be exercised by any individual in the person's life, it is not necessarily restricted to immediate family members;
3. Important factors that would give rise to a suspicion that undue influence is being exercised include a person, family member or otherwise, who appear to exercise dominion and ascendency over the person;
4. Whether a person is likely to be unduly influenced is a subjective test, and can vary person to person;
5. Undue influence focusses on overbearing influence/persuasion that undermine the person's ability to exercise their free will. Several important factors that may directly undermine the person's will, include
    a. their state of health;

[42] [1971] VR 573.
[43] *Union Fidelity Trustee* (n 28) 577 (Gillard J).
[44] These factors have been considered of crucial importance to questions of undue influence in several seminal cases: see, eg, *Johnson* (n 28) 119 (Starke J); *Spong v Spong* (1914) 18 CLR 544; *Watkins v Combes* (1922) 30 CLR 180, 192 (Isaccs J).

b. age;
c. mental health;
d. level of intelligence;
e. character and personality;
f. level of dependence on others for care and support;
g. living circumstances and level of familial support.

This list is not intended to be exhaustive and was developed to serve as an illustration. Whilst these considerations might assist in providing clarity on undue influence, it may have the unintended side effect of rendering assessment of undue influence an arduous task. For instance, when the courts are called upon to determine undue influence, the parties in the dispute have been identified and the issues confined. However, in the context of VAD, no such parameters have been set; consequently, this is likely to require medical practitioners and witnesses to examine innumerable unknown persons known to the patient who may be in a position to exercise undue influence, which is unrealistic. It would also require them to engage in an intricate consideration of the person's broader circumstances and their individual personality to identify first, who might exercise undue influence on them, and second, how susceptible they are to being unduly influenced.

Additionally, undue influence is often a covert type of behaviour that occurs behind closed doors, which makes it very difficult to identify in the abstract, especially if the individual exercising undue influence is acting with sinister intention. It was not clarified in the VAD bills or the *Hansard* whether those tasked with assessing undue influence had to undertake a fact-finding mission or assess for undue influence on the basis of what is presented to them, which further illustrates the ambiguity surrounding the statutory protection. However, given the complexity of the test, it is likely that assessment of undue

influence would need to be performed by someone with particular expertise in communication or interviewing to uncover relevant facts and then make a determination based on the evidence, which was not the position taken in the DWD Bill.

It is difficult to pre-empt what meaning the legislature may attribute to undue influence should this path be taken. It was considered at the outset of this discussion in [16.30] that a bizarre complexity is evident in the *VAD Act* (SA) as a result of the inclusion of the term 'undue influence' as a key principle, although screening of it has been excluded as a statutory safeguard. It is clear that the statutory safeguards that aim to protect a voluntary consent in the *VAD Act* (SA) require clarification and the key term adopted — 'coercion' — under the law has not been defined. Language, especially terms of legal origin, have specific meaning and it is careless to borrow terms, especially terms burdened with a rich judicial history, from the law without reflecting on whether they are capable of serving the purpose intended. If assessment of undue influence is to make its way into regulation passed under the *VAD Act* (SA), which can occur, then clarity concerning the definition and scope must be provided if it is to provide meaningful protection of a voluntary decision. This thesis serves as a cautionary tale regarding careless adoption of terms such as undue influence.

It was not the purpose of this chapter to develop a definition of undue influence for use in the area of VAD, nor to establish guidelines that would facilitate in undertaking assessment of it. The aim was to shine a light on the complexities surrounding undue influence as a legal term and consequences that are likely to arise as a result of including it as a statutory safeguard in proposed VAD law. That is not to say that developing a working test for undue influence in this area would not be beneficial — it would. Rather, it is acknowledging that solely relying on the legislature to develop such a test would not

be desirable and is potentially myopic. The key point that can be extrapolated here is that care must be taken before adopting legal terms of art in narrow legislative contexts. In the circumstances of VAD, a screening test for undue influence would be aimed at both medical practitioners and the general public, meaning that this issue should be viewed through a multi-disciplinary lens. In stating this, it is not conceding that the discipline of law cannot provide a suitable answer, it is simply recognising that the law has its limitations. Because VAD is such a serious matter, a broader focus that includes the legal profession is likely to result in a better outcome for patients, whose safety is the paramount consideration. Notwithstanding this issue, significant flaws exist with the past response to protecting against undue influence, which are likely to pose unacceptable risks to medical practitioners who are obligated to safeguarding against it, and for patients, whose safety and protection is the focus of these safeguards. It is consideration of these risks to which this discussion now turns.

Chapter 17: Through a lens of risk: risk to the patient and the medical practitioner

Introduction

[17.10] It has now been established that there is substantial uncertainty and ambiguity concerning the meaning and operation of undue influence in proposed VAD legislation in South Australia. As result of this uncertainty, the efficacy of the safeguards designed to protect against undue influence are significantly undermined. Consequently, instead of providing any protection against undue influence, it could have the same effect as placing a strong magnet near a compass — navigational errors and misdirection. The previous chapter examined the issues that may arise as a result of this omission, observing that the cumulative effect of these issues is likely to pose unacceptable risks to the patient and the medical practitioner.

Risk to the patient

[17.20] The failure to ensure that undue influence is clearly and unambiguously defined creates concerning risks to patients requesting VAD. The decision to request VAD — to decide to end your life because your existence has become defined by illness, intolerable pain and suffering — is undoubtedly one of the most important decisions an individual will make in their life time. Given the gravity of VAD, this is a decision that must be voluntary. That voluntariness must be strongly protected from behaviour that would undermine it. It is evident that the South Australian legislature recognised that protecting a voluntary decision was necessary, and determined that screening for undue influence in a request formed a pivotal statutory safeguard. However, significant flaws are evident in the proposed statutory drafting to protect against undue influence, which call into

question its efficacy as a core safeguard. It is unclear how medical practitioners and lay witnesses who were duty bound to screen for undue influence could undertake an assessment of it, without being provided with the necessary tools to screen for it.

The purpose of the undue influence safeguard was to ensure that the individual requesting VAD was not being subjected to unacceptable pressure by someone in their external environment to request VAD. Thus, it requires the person called upon to assess for undue influence to look beyond the individual to ascertain whether someone was actively influencing or pressuring them, in an impermissible manner, to request VAD. Without sufficient guidance and clarity regarding how to even undertake such an examination, this is highly likely to be misunderstood, resulting in errors.

It is unlikely that the legislature, in safeguarding against undue influence, intended to separate the individual requesting VAD from their support network. Important healthcare decisions are oftentimes discussed in the presence of family and friends who will be affected by the decision.[1] It is accepted in Australia that healthcare decisions can be made in the broader context of familial and social relationships and interactions.[2] Indeed, a failure to encourage or empower supported decision-making would inappropriately isolate patients from their support network and would be an erroneous position to take, and would arguably be inconsistent with good medical practice.[3] However, the pertinent issue is that whilst shared decision-making is supported, the medical practitioners and

[1] This role of family and friends in the decision-making process was highlighted in the case of *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95 ('*Re T*'). In this case, the Court emphasised that patients were indeed entitled to have conversations about their healthcare and make such decisions in the context of discussions with others; however, the pivotal consideration is that the decision must ultimately be the patients: see also *Application of a Local Health District: Re a Patient Fay* [2016] NSWSC 624 ('*Re Fay*').
[2] The involvement of family in healthcare decisions and the shared decision-making model is expressed in medical codes of conduct in Australia. See, eg, Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Web Page, 2014) 2.3 <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>.
[3] Ibid.

lay witnesses must be satisfied that the decision is indeed that of the patient. If the persons called upon to assess for undue influence are unable to properly perform this obligation because they have not been given any direction, a likely outcome is that they will not be able to identify undue influence, and therefore fail to ensure that the patient was making a voluntary decision. Given that VAD is unquestionably a matter of life or death, there is no scope for uncertainty with the statutory response designed to protect a voluntary decision. Errors cannot be remedied. This failure may result in an affront to the individual's right to exercise autonomy over their body. Autonomy must be rigorously protected when the decision at hand involves consenting to one's death. As it stands, it is not possible to draw a convincing conclusion that the proposed response to safeguarding against undue influence can protect autonomy.

The right to exercise autonomy over healthcare decisions is a well-established rule in Australian common law.[4] Respect for autonomy, exemplified by a capable adult's right to decide what is and what is not done to their body,[5] underpins the duty placed on medical practitioners to obtain a valid consent before treating a competent patient. Indeed, this principle is so highly protected at law that the failure to obtain a valid consent prior to treatment can result in the medical practitioner being found liable in tort, via trespass to the person.[6] However, for a consent to be valid, several conditions must be satisfied.[7]

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[4] See generally *H Ltd v J* [2010] SASC 176 ('*H Ltd*'); *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229, [24], [26], [31] (Martin CJ); *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 92 (McDougall J) ('*Hunter*').

[5] See generally *Secretary, Department of Health and Community Services v JWB* 106 ALR 385, 391-92 (Mason CJ, Dawson, Toohey and Gaudron JJ) ('*Marion's Case*'); see also *Schloendorff v Society of New York Hospital* 211 NY 125 (1914), 129 (Cardozo J).

[6] See *Murray v McCurchy* (1949) 2 DLR 442; *Candutti v ACT Health and Community Care* [2003] ACTSC 95; *Marion's Case,* 391–92 (Mason CJ, Dawson, Toohey and Gaudron JJ); see also *Riebl v Hughes* (1980) 114 DLR 3d 1, 10 (Laskin CJC); Bernadette Richards, 'General Principles of Consent to Medical Treatment' in Ben White, Fiona McDonald and Lindy Willmott, *Health Law in Australia* (Thomson Reuters, 3rd ed, 2018) 135–157; Bill Madden, Janine McIlwraith and Benjamin Madden, *Australian Medical Liability* (LexisNexis Butterworths, 3rd ed, 2017) 13-23.

[7] See generally Richards in White, McDonald and Willmott (eds) (n 6) 135–57.

The element relevant to this discussion is that consent must be expressed freely and voluntarily, which is recognised at common law and in the broader literature on consent to medical treatment.[8] It is evident that the South Australian legislature intended to give legislative expression to existing common law principles by incorporating protection against undue influence[9] — and duress — in several of the VAD bills.[10] However, limitations are evident in the proposed statutory response to safeguarding against undue influence. Therefore, if one of the protections that form part of the foundation of the voluntary consent framework has significant cracks, is the entire foundation then at risk of collapse? What protection can assessment of undue influence provide to patients if there is so much uncertainty surrounding its scope and operation that the people called upon to identify it are likely unable to do so? Consequently, the well-established legal duty to ensure that a consent to medical treatment has been expressed voluntarily, which aims to protect individual autonomy, is undermined. When the decision is death, this is an unacceptable risk. The threat to the patient is that this is an affront to their autonomy. This has the effect of depriving the individual of their fundamental right to be the narrator of their life and death. This is an egregious error and must be remedied. However, a far more sinister side effect arises due to the omission to impute clarity and meaning to the undue influence safeguards — that is, it can result in a non-voluntary death.

Much of the rhetoric surrounding the VAD debate in South Australia focused on the notion that voluntariness was well protected, and that behaviour that sought to undermine it was capable of being identified. Examples of these rhetorical statements were provided in

[8] See above n 6.
[9] It was examined in Chapter 15 that medical undue influence — although yet to be considered by a court of South Australian jurisdiction — has been recognised in *obiter* as grounds to invalidate a consent to medical treatment on the grounds that consent was not voluntarily given: see *H Ltd* (n 4) [40] (Kourakis J); see also *Hunter* (n 4) 97-8, [40].
[10] See Table 5.

Chapter 5. For instance, in the Second Reading speech to the Legislative Council for the Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA) ('ELA Bill'), Mark Parnell emphasised the paramountcy placed on safeguarding a voluntary decision, stating that

> the key element, and I have said this as often as I can when talking about this, V is for 'voluntary'. It is about voluntary euthanasia. I distinguish it from straight euthanasia, which is where you take your dog to the vet and ask for it to be put down as an act of compassion. The dog is not the one making the choice, you are. Voluntary euthanasia is all about the patient themselves making a choice about their life.[11]

Therefore, according to Mark Parnell, safeguarding voluntary choice was central to the ELA Bill and it was highlighted that this bill went further than previous VAD bills to ensure that this end was met. Whilst this sounds convincing, how voluntary is the 'choice' if the statutory safeguards designed to protect a voluntary decision are ambiguous and convoluted. The individuals — medical practitioners and witnesses — obligated to protect against undue influence are unlikely to be in a position to identify the very behaviour that operates to abrogate voluntary choice and taint the decision. This reflects a limited understanding of the complex nature of the doctrine of undue influence and its meaning and application in equity and the common law.

This lack of critical reflection comes at a great risk to patients — the risk of a non-voluntary death. No posthumous remedy can be awarded by a court to compensate for this error. It is not possible to go back in time to remedy the mistake: the individual will still be dead, and their death would still have been non-voluntary. The risk to the patient is *their* life and greater protection of *their* choice is crucial. However, the flawed position on safeguarding against undue influence has implications not only for patients, but for the

[11] South Australia, *Hansard,* Legislative Council, 29 September 2010, 964 (Mark Parnell).

medical practitioners involved in the process and is likely to place them at risk of harm too.

Risk to the medical practitioner

[17.30] The paramount consideration in any VAD legislation should be protection of the patient. However, medical practitioners are also likely to be at risk of harm as a consequence of the ambiguity concerning the undue influence safeguards. Although many of the previous VAD bills tabled in the Parliament of South Australian provided medical practitioners with protection from liability, immunity from criminal and civil liability and professional disciplinary action was not absolute.[12] For example, under the Death with Dignity Bill ('DWD Bill'),[13] the medical practitioner was protected from liability if they participated in VAD according to the criteria set out in the legislation.[14] Section 20 explained that if a medical practitioner takes part in 'the making of a request or a purported request [for VAD]'[15] or 'takes part in … the administration of [VAD] in accordance with the Act,'[16] then they incur 'no criminal liability for an act or omission'[17] and incur 'no civil liability for an act or omission … provided that [it] was done or made in good faith and without negligence'.[18] Furthermore, civil liability was defined to include

[12] See, eg, Death with Dignity Bill 2016 (SA) ('DWD Bill') s 20; Voluntary Euthanasia Bill 2016 (SA) ('VE Bill') s 22; Voluntary Euthanasia Bill 2012 (SA) s 13; Ending Life with Dignity Bill (no 2) 2013 (SA) s 30; Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA) s 51; Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (SA) s 48; Voluntary Euthanasia Bill 2006 (SA) s 13; Voluntary Euthanasia Bill 2007 (SA) s 13; Voluntary Euthanasia Bill 2008 (SA) s 13; Voluntary Euthanasia Bill 2010 (SA) s 13; Dignity in Dying Bill 2005 (SA) s 16; Ending Life with Dignity Bill 2013 (SA) s 31.
[13] (2016) (SA).
[14] DWD Bill s 20.
[15] Ibid s 20(1)(a).
[16] Ibid s 20(1)(b).
[17] Ibid s 20(1)(c).
[18] Ibid s 20(3).

immunity from professional disciplinary proceedings.[19] However, the protection from liability did not extend to immunity from offences created under the DWD Bill.[20] Upon closer examination of the wording of s 20(1)(d) of the DWD Bill it appears that immunity from civil liability was intended to be broad as it protected medical practitioners from acts or omissions, most likely construed to include cases of non-compliance with the law, as long as they were done in good faith and without negligence.[21]

Screening for undue influence was one of the legislative safeguards included under the making of a request for VAD provisions.[22] Therefore, the immunity extended to assessment of undue influence. The relevant provisions in the DWD Bill required the medical practitioner, depending on whether they were performing the first or second assessment and examination, to have either a reasonable suspicion or be of the opinion that the person was acting under any form of undue influence.[23] Referral to a psychiatrist was discretionary and would only be engaged if the first or second medical practitioner suspected that undue influence was being exerted.[24] Therefore, the first and second

[19] Ibid s 20(1)(d).
[20] Ibid ss 20(1)(c), 20(3). The same broad protection from liability was also included in the VE Bill in s 22. The protection from liability adopted under the DWD Bill and VE Bill appear to be much broader than the position taken in other South Australian VAD bills. Many of the previous bills did not include protection from liability for acts or omissions done in good faith and without negligence, thus potentially adopting a stricter position concerning cases of alleged non-contravention with the law: see, eg, Voluntary Euthanasia Bill 2012 (SA) s 13; Ending Life with Dignity Bill 2013 (SA) s 31; Dignity in Dying Bill 2005 (SA) s 16.
[21] This broad protection from liability is similar to the position adopted in many of the US Jurisdictions, discussed in Chapter 9, where good faith compliance serves as a protection against liability. In the State of Oregon, USA, the compliance review body, the Oregon Health Authority, has referred cases of non-compliance to the Oregon Medical Board for further review; however, no sanctions have been placed against those physicians for non-compliance with the legislation as they were deemed to have acted in good faith. For further discussion, see Chapter 9.
[22] See DWD Bill ss 11(2)(c), 10(1)(g)(v).
[23] Ibid ss 11(2)(c), 12(2)(c).
[24] It is uncertain whether psychiatrists know what undue influence is or are in a better position to assess for undue influence in a request for VAD. Consideration of this issue is beyond the scope of this thesis. The position adopted here is that undue influence is a convoluted legal term and its application as a statutory safeguard in proposed VAD legislation in South Australia is inappropriate.

medical practitioners were positioned as primary gatekeepers on matters of undue influence and therefore will be the focus of this discussion.

It has already been established that the meaning of undue influence under the DWD Bill — and all VAD bills where this was included as a safeguard — was uncertain.[25] It was never defined, and no guidance regarding how assessment of undue influence should be performed was provided. A likely consequence of this ambiguity is that this may directly impede the medical practitioner's ability to form either a reasonable suspicion or opinion on matters of undue influence and constitute a failure to discharge this obligation to a proper professional standard.

The DWD Bill did not establish a compliance review board or the like.[26] The limited information concerning the review procedure makes it difficult to argue what impact this was likely to have on medical practitioners. However, it is inferred by analogy to the position adopted in other jurisdictions[27] that an independent review body would be established to perform compliance review if this bill were enacted. The risk that may eventuate as an outcome of this lack of clarity concerning undue influence is that when the request was being reviewed by an independent board for compliance it may be determined that the medical practitioner failed to adequately assess for undue influence in a request for VAD, which may lead to referral to another body for further investigation.

[25] See Chapter 16 for discussion on the ambiguity with undue influence in proposed VAD legislation in South Australia.
[26] The DWD Bill was silent concerning how review of granted requests for VAD would be performed. The DWD Bill did permit the Governor to make regulations that were necessary for the purposes of the law, thus permitting the legislature to enact regulations to establish and govern the review procedure if they chose to do so: see s 35(1).
[27] An overview of the VAD review boards and committees, as well as review procedure was provided for each of the jurisdictions, are considered in Part 2. For further information concerning the composition of these boards and procedures, see Part 2. The *Voluntary Assisted Dying Act 2021* (SA) establishes the Voluntary Assisted Dying Review Board whose function, inter alia, is to determine compliance with the legislative criteria and refer any matters to other agencies for investigation: see especially s 113(1)(e); see also ss 107–24.

It is difficult to pre-empt or discuss in the abstract what the response to such a referral may be — that is, what type of liability this would attract. However, the first step may constitute referral to the Australian Health Practitioner Regulation Agency ('AHPRA') for review, thus rendering it a disciplinary matter.

A recent example of a case of non-compliance with the legislative requirements that supports this inference was discussed in the Voluntary Assisted Dying Review Board's ('VAD Review Board') Report of Operations in Victoria.[28] In the latest report on VAD published by the VAD Review Board covering the period January to June 2020, it was reported that one case of non-compliance with the law was identified.[29] Whilst it was emphasised that the individual who received the VAD permit was eligible to do so, the medical practitioner failed to adhere with the 'procedural requirements of the Act'[30] and the matter was referred to AHPRA for review. No further discussion or clarification was provided by the VAD Review Board concerning the particulars of the case, therefore it remains to be seen what legislative requirement or requirements were not complied with. However, the non-compliance was 'procedural' in nature, which is generally perceived as being a less serious violation of the law; however, as the matter was still referred to AHPRA for review it was clearly of some import. Under the DWD Bill, the failure to properly assess for undue influence is most likely considered breach of a substantive safeguard, suggesting that this could be treated more severely, attracting a more significant response than breach of a procedural criterion. Therefore, the risk that may arise as a consequence of the legislature's failure to impute sufficient clarity into the

[28] Voluntary Assisted Dying Review Board, *Report of Operations (January to June 2020)* (Web Page, 13 November 2020) <https://www.bettersafercare.vic.gov.au/publications/VADRB-january-to-june-2020>.
[29] Ibid.
[30] Ibid 15.

undue influence safeguards is that the medical practitioner could, at a minimum, be referred to AHPRA for investigation.

It was discussed at the outset of this section that the position adopted under the DWD Bill appeared to provide immunity from civil liability for acts of non-compliance if they were performed in good faith and without negligence.[31] Determination of whether the medical practitioner acted in good faith or not is unlikely to be determined at a board level, which is the position adopted in Victoria,[32] and would still require referral to AHPRA or the Medical Board of Australia for consideration. Even if it was subsequently determined that the act or omission was done in good faith, thus attracting no penalty or censure, it is an unacceptable risk to assume, especially if the risk is one that arose as a consequence of the failure to clarify the standard required in this circumstance. The risk of potential professional disciplinary action, whether well founded or not, may have broader negative implications, and may result in an unwillingness for that medical practitioner or indeed other medical practitioners to participate in VAD. This may in turn directly affect individuals' ability to access VAD due to a decline in the number of medical practitioners willing to perform VAD, as the risk of liability would outweigh any benefit to provide VAD. The DWD Bill, the Voluntary Euthanasia Bill ('VE Bill') and the Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA) ('ELA Bill')) were the only instruments that provided immunity from liability for acts or omissions performed in good faith.[33] The position concerning immunity from civil and

[31] See **[17.30]**.
[32] See Voluntary Assisted Dying Review Board, *Report of Operations (January to June 2020)* (Web Page, 13 November 2020) <https://www.bettersafercare.vic.gov.au/publications/VADRB-january-to-june-2020>. Similar frameworks are implemented in other jurisdictions, such as the Netherlands and Oregon, USA. For discussion, see Chapters 9 and 11.
[33] DWD Bill 2016 (SA) s 20; VE Bill s 22; Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010 (SA) s 51. Good faith compliance is a well-entrenched concept in PAD in the US jurisdictions and was discussed in Chapter 9.

criminal liability in the remaining VAD bills *appeared* to be narrower, as there was no reference to 'good faith'.[34] Therefore, it appears that protection from liability under the Ending Life with Dignity Bill 2013, Ending Life with Dignity Bill (no 2) 2013 (SA) and the Voluntary Euthanasia Bill 2021 (SA) is not as broad as the protections offered in the DWD Bill, the VE Bill and the ELC Bill, likely placing medical practitioners at a heightened risk of harm. It is, however, not possible to develop this argument further due to limited information. The risk remains a real possibility nonetheless.

Legalising VAD is fraught with risk. It is a practice that is contrary to well-established principles of criminal law against the intentional ending of the life of another person, or actively assisting them to end their own life.[35] However, significant advances in health and medical science have occurred over the past century or so, which have forced us to reconsider our attitudes towards such acts and the respective legal response. Advances in medicine have resulted in an increase in life expectancy; this does not, however, guarantee a life free of illness and intolerable suffering.[36] There are limits on what we can control and, despite best efforts, our health is something that is beyond that control. There is a growing recognition that individuals who are diagnosed with a terminal or incurable illness should be not be left to suffer and should be given the right to request VAD.[37] It is evident that the South Australian legislature attempted to balance the competing interests of the right to autonomy by including VAD as a lawful end-of-life practice, and protection of vulnerable individuals by including protection against undue influence as one of many key statutory safeguards. Whilst broad protection of a voluntary decision is mandatory in

[34] See Ending Life with Dignity Bill (no 2) 2013 (SA) s 30; Ending Life with Dignity Bill 2013 (SA) s 31; Voluntary Euthanasia Bill 2012 (SA) s 12.
[35] See *Criminal Law Consolidation Act 1936* (SA) ss 11, 13A.
[36] Research indicates that deaths due to cancer and chronic illness are leading causes of deaths in Australia: see 'Causes of Death Australia', *Australian Bureau of Statistics* (Web Page, 31 March 2021) <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2019>.
[37] This is evident by the rapid increase in jurisdictions enacting, or considering enactment of, VAD legislation: see Part 2 for discussion.

the area of VAD, the response in South Australia to safeguard against undue influence has been flawed. There was significant ambiguity surrounding this term and this must be avoided. The consequences of failing to do so can have deleterious consequences for patients requesting VAD and medical practitioners called upon to approve the request. The safeguards against undue influence are unlikely to provide any meaningful protection of a voluntary decision and have the unintended consequence of exposing the medical practitioner to risk of professional disciplinary liability at a minimum. This must be remedied by establishing a multi-disciplinary panel of experts to devise an appropriate framework for the benefit of both patients and medical practitioners, which is considered in the following, final chapter of this thesis.

Meaningful protection of a voluntary decision?

[18.10] It has been illustrated that protection of a voluntary decision by safeguarding against undue influence was historically a popular mechanism devised by the legislature to protect the vital principle of voluntariness in the decision-making process for VAD. Yet it was a flawed approach that likely failed to meet this purpose. Instead of providing meaningful protection of a patient's decision, it had the unintended consequence of creating unacceptable risk for both patients and medical practitioners. Now that the issues with undue influence have been clearly articulated, the vital question becomes what is the best path forward?

The scope of this thesis was limited to a critique of the existing approach proposed in several South Australian VAD bills concerning safeguarding a voluntary decision, highlighting the risks that arose as a result of the sustained lack of critical reflection by the Parliament of South Australia concerning the scope and operation of undue influence safeguards. That is not to say that the legislature was wrong in recognising that broad protection of a voluntary decision was a necessary protection in VAD legislation — it is. However, the reliance on the doctrine of undue influence was infelicitous. This serves as an example of the risks associated with the adoption of terminology that was developed to meet other challenges.

The best path forward…

Recommendation 1: Convene an expert panel to research and review how to meaningfully safeguard a request from undue influence

[18.20] Broad protection of a voluntary decision is mandatory in any VAD framework — that ethos is not challenged in this thesis. The position adopted throughout this discussion was that undue influence was inappropriate as a statutory protection for a voluntary decision because it is a legal term that does not have an ordinary meaning. The introduction of undue influence into unfamiliar milieu without explication or guidance raises pertinent issues concerning how efficacious this test would be in a practical setting. Chapters 15 and 16 examined these issues but stopped short of developing a framework to address the perceived concerns. The appropriate response regarding what the framework of protections against undue influence should look like cannot, and should not, be provided by the legal profession alone. Rather, it must be the product of an intricate and well-reasoned debate from a multidisciplinary panel of experts.

The reluctance to devise a purely legal answer is not conceding that the law cannot satisfactorily address this issue, but rather it recognises that the law — and this thesis — has its limitations. The focus of the statutory safeguards in VAD is, and should be, protection of the patient. Their best interests *must* be the paramount consideration. Assessment and examination of undue influence in a request for VAD under the DWD Bill and other legislative instruments were to be performed by medical practitioners and the general public called upon to act as witnesses. Consequently, the best response that will take into consideration the patient's best interests — and the medical practitioner's interests — is one that that is devised by a broad community of experts, including members of the legal profession. Such approaches are not uncommon in the area of VAD and governments in other jurisdictions have taken similar steps to research and report

on the complicated and sensitive issues inherent in VAD to devise the appropriate statutory response.[1]

A recent example of this approach is evident in Canada, where the Federal Government recently enacted *An Act to Amend the Criminal Code* (*Medical Assistance in Dying*)[2] ('Bill C-7'), which introduced a suite of amendments to the *An Act to Amend the Criminal Code and to make Amendments to other Acts (Medical Assistance in Dying)* ('*MAID Act*').[3] The changes implemented by Bill C-7 were broad and will not be discussed here as they have been considered elsewhere.[4] Of relevance to this discussion is that the initial version of Bill C-7 introduced in the House of Assembly included a provision excluding mental illness from being considered an illness, disease or disability for the purpose of the *MAID Act*, thus explicitly restricting individuals who were suffering from psychiatric illness alone from requesting Medical Assistance in Dying ('MAiD'). This exclusionary provision proved to be a contentious issue when Bill C-7 was being debated before the Senate who voted for its repeal by introducing a sunset clause on this provision.[5] The House of Assembly eventually adopted the Senate's Motion, and the mental illness exclusionary provision will

[1] Further evidence of this approach being adopted is evident in Victoria, Australia. Following the Parliamentary Committee's Inquiry into End of Life Choices in Victoria, the State Government convened two advisory panels to conduct research into and advise the State Government on an appropriate framework to safely establish voluntary assisted dying: see, eg, Legal and Social Issues Committee, Parliament of Victoria, *Inquiry into End of Life Choices* (Final Report, 9 June 2016) < https://www.parliament.vic.gov.au/402-lsic-lc/inquiry-into-end-of-life-choices>; health.vic, 'Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report', *Victoria State Government* (Web Page, 31 July 2017) <https://www2.health.vic.gov.au/about/publications/researchandreports/ministerial-advisory-panel-on-voluntary-assisted-dying-final-report#:~:text=The%20Voluntary%20Assisted%20Dying%20Ministerial,Panel's%20recommendations%20for%20the%20framework.>; health.vic, 'Voluntary Assisted Dying Bill Discussion Paper', *Victoria State Government* (Web Page, 25 January 2017) <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/voluntary-assisted-dying-bill-discussion-paper>.

[2] *An Act to Amend the Criminal Code (Medical Assistance in Dying),* RSC 2020-2021, c C-46 ('Bill C-7').

[3] *An Act to Amend the Criminal Code and to make Amendments to other Acts (Medical Assistance in Dying)*, RSC 2015-2016, c C-14 ('MAID Act').

[4] Michaela Estelle Okninski, 'Canada Passes C-7' (2021) 18 *Journal of Bioethical Inquiry* (forthcoming).

[5] Federal Parliament (Canada), *Debates of the Senate*, Senate, 9 February 2021, 851–854 (Senator the Hon Stan Kutcher).

be repealed in March 2023.[6] In recognising that extending MAiD to individuals whose sole underlying condition is psychiatric illness is contentious and raises significant ethical issues,[7] the legislature established an 'independent review to be carried out by experts respecting recommended protocols, guidance and safeguards to apply to requests made for [MAiD] by persons who have a mental illness' to be convened during the sunset period.[8] This approach was taken to ensure that an appropriate system of safeguards specific to mental illness can be introduced to reflect the complexity and nuanced nature of suffering experienced by individuals afflicted with mental illness.[9] It is evident that the mandate of the independent panel of experts is limited in focus, considering issues that specifically arise, directly and/or by implication, regarding MAiD for mental conditions/illnesses. Such an approach would be beneficial in South Australia.

It is, therefore, recommended that the Parliament of South Australian establish a panel of experts, constituted by members including, but not limited to, the legal profession — both practitioners and legal scholars — the medical profession (for example, geriatricians, palliative care specialists, psychiatrists, oncologists, rehabilitation specialists, and neurologists) ethicists, and members of the general public. The mandate of this expert panel would be to review reliance on the term 'undue influence' as a statutory safeguard for a voluntary consent. This professional diversity is likely to be representative of the key stakeholders involved in safeguarding a voluntary decision in VAD legislation, thus resulting in an informed and meaningful discussion.

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[6] See Bill C-7 ss 6, 1(2.1).
[7] See generally Kathleen Sheehan, K Sonu Gaind and James Downar, 'Medical Assistance in Dying: Special Issues for Patients with Mental Illness' (2017) 30(1) *Current Opinion in Psychiatry* 26; Scott Kim and Trudo Lemmens, 'Should Assisted Dying in Canada for Psychiatric Disorders be Legalized in Canada?' (2016) 188(14) *Canadian Medical Association Journal* 337; Joris Vandenberghe, 'Physician-Assisted Suicide and Psychiatric Illness' (2018) 378(10) *New England Journal of Medicine* 885.
[8] Bill C-7 3.1(1).
[9] See Federal Parliament (Canada), *Commons Debates*, House of Assembly, 23 February 2021, 4416-417 (David Lametti (Minister of Justice)); Federal Parliament, *Commons Debates*, House of Assembly, 9 October 2020, 788-89 (David Lametti (Minister of Justice)).

It is essential that the mandate of this 'expert panel' remain narrow in focus, limited to consideration of how the existing approach to safeguarding a voluntary decision against undue influence — and perhaps safeguarding a voluntary decision in general — can be translated into practice. Naturally, this would include consideration of whether undue influence is appropriate in this situation, whether it should be retained as a proposed legislative safeguard — that is, can it be defined and supplemented by guidelines to transform it into a meaningful protection — or should it be replaced by another term better suited to achieve the objective of providing broad protection of a voluntary decision. It is important that steps are taken to avoid broadening the focus of the mandate, as this has the potential to dilute the discussion. VAD raises many complicated issues — how to adequately safeguard a voluntary decision is just one of them. Failure to limit the discussion could result in consideration of undue influence and safeguarding a voluntary decision being subsumed under another topic; for instance, capacity, which also concerns voluntariness, or not being given due consideration as the focus of the debate may become overshadowed by other issues. Thus, the narrow focus is essential. The outcome of this review on undue influence and safeguarding a voluntary consent could be to generate a test or guidelines that can be implemented in practice for medical practitioners and the general public called upon to act as witnesses. Imputing guidance and clarity into undue influence safeguards is likely to mitigate the risks to patients and medical practitioners that were the focus of Chapter 17.

Legalisation of VAD has occurred in South Australia, therefore further research into this matter is mandatory prior to implementation of the *VAD Act* (SA). Although the legislature adopted a different position concerning safeguarding a voluntary decision under the *VAD Act* (SA) by excluding screening for undue influence as a substantive safeguard, ambiguity

still exists concerning the approach to safeguarding against external pressure in general which needs to be clarified.

The statutory tests introduced to safeguard a voluntary consent in the *VAD Act* (SA) are 'acting voluntarily and without coercion'.[10] This approach was inconsistent with previous VAD bills tabled in parliament in the 2010s, including the DWD Bill which preceded the *VAD Act* (SA) where undue influence was a regular protection. The underlying rationale for this shift in terminology was not the product of an informed or well-reasoned debate regarding the inappropriateness of the term 'undue influence' but was rather the result of the legislature simply replicating the Victorian model of VAD.

For instance, in his Second Reading speech to the Legislative Council, Kyam Maher indicated 'that this bill is a direct translation of the Victorian model, which has been described as the safest and most conservative scheme in the world by the Victorian Premier, with some 68 safeguards in place'.[11] Thus, it appears that this change in trajectory was simply the product of mirroring a regime that proved successful elsewhere. Although undue influence has been omitted as a proposed statutory safeguard, this development is not likely to have a disadvantageous impact on this recommendation.

The terminology preferred in the *VAD Act* (SA) with regards to safeguarding a voluntary decision has not been clarified. Further research concerning what is the best framework to protect a voluntary decision broadly is necessary. It was addressed in Chapter 1 that the *VAD Act* (SA) included the right to make medical decisions free from coercion and

[10] See, eg, *VAD Act* (SA) ss 26(1)(e), 38(1)(c), 47(1)(c), 64(c)(iii) 82(2)(a)(ii), 83(1)(c).
[11] South Australia, *Hansard,* Legislative Council, 2 December 2020, 2348 (Kyam Maher, Leader of the Opposition).

undue influence as a key principle of the Act,[12] although only protection against coercion is mandated a statutory safeguard. The delineation between coercion and undue influence is evidence enough that they are distinct terms. Yet this distinction is not reflected in the *VAD Act* (SA), as only protection against coercion is mandated. The issue that arises is how can this principle be achieved if only protection against coercion is required. Thus, it is evident that there is an incongruity here which must be resolved prior to commencement of the Act. Therefore, a multi-disciplinary panel of experts should be convened to investigate how meaningful protection of a voluntary decision overall can be achieved reflecting the new approach adopted under the recently passed *VAD Act* (SA). Broad protection of a voluntary decision, which appeared to be the impetus behind including undue influence as a statutory safeguard, was never challenged in this thesis. Rather it was the choice of terminology that was criticised. The statutory response to protecting voluntary choice should remain broad, as the behaviour that seeks to vitiate voluntariness has many faces, just like the patients who will request VAD.

Recommendation 2: Safeguarding voluntariness in other jurisdictions — what can the experience in other jurisdictions teach us?

[18.30] It can be said, almost beyond doubt, that the experience of VAD in other jurisdictions has an influential impact on legislatures considering VAD. For instance, evidence regarding the experience of VAD in the Netherlands, Belgium and Oregon was considered in great detail and was highly persuasive in the case of *Carter v Canada* ('*Carter*').[13] More recently, the Parliament of South Australia's Report of the Joint

[12] *VAD Act* (SA) s 8(1)(k).
[13] [2015] 1 RCS 331, 384–88, [110]-[119]. Discussion on the experience of VAD in other jurisdictions was discussed in great detail at first instance by Smith J in *British Columbia Supreme Court,* 2012 BCSC 886, 287 C.C.C. (3d) 1. On appeal to the Supreme Court of Canada, the plurality accepted Smith J's finding of

Committee on End of Life Choices ('JC ELC') examined similar data; however, unlike the court in *Carter*, in was not the mandate of the JC ELC to draw conclusions, or make findings on, the opposing evidence.[14]

Part 2 of this thesis considered the legislative response to safeguarding a voluntary consent in other jurisdictions where VAD legislation is currently in force. The comparative legal analysis was limited in focus and only considered the legislative response to safeguarding a voluntary consent from types of external pressure that would undermine the voluntariness of the decision-making process. It was observed that the response to safeguarding voluntary consent differed in several of these jurisdictions with regard to both the terminology used and the procedure mandated to protect a voluntary decision. To avoid unnecessary repetition, the key differences will not be reproduced here and can be found in Table 6. This comparative analysis focused on several key areas of the law relating to safeguarding a voluntary decision, which were the

- terminology adopted in the legislation itself;
- review procedure mandated under the legislation; and
- interpretation of the key terminology.[15]

Key differences were evident amongst some jurisdictions; however, the notable shared characteristic was recognition of the fact that broad protection of a voluntary decision was mandatory. Each jurisdiction had safeguards in place that aimed to ensure that the patient's decision was voluntary, which required assessment of whether the patient was

facts in relation to the experience of VAD in other jurisdictions, giving them positive treatment: see *British Columbia Supreme Court,* 2012 BCSC 886, 287 C.C.C. (3d) 1, [359]-672]. See Chapter 10 for discussion on the *MAID Act* in Canada.

[14] Joint Committee on End of Life Choices, Parliament of South Australia, *Report of the Joint Committee on End of Life Choices* (Report, 13 October 2020) 20-35.

[15] See Part 2 for further discussion of these areas in each jurisdiction.

being coerced, unduly influenced or under the influence of some form of unacceptable external pressure from a third party to make a request for VAD. The important issue that now must be considered is whether the legislative response to safeguarding a voluntary decision in other jurisdictions has any value for the South Australian legislature.

Examination of the experience of VAD in other jurisdictions will provide invaluable information and direction for South Australia moving forward. If South Australia adopts Recommendation 1 above, then the discussion provided in Part 2 of this thesis is important, as it provides critical reflection with regard to the legislative approach adopted in each jurisdiction concerning safeguarding a voluntary decision. The discussion in Part 2 went beyond a mere descriptive analysis of the legislative provisions and sought to examine and compare the entire response to safeguarding a voluntary decision from some form of external pressure. Part 2 was broader in focus, as not all jurisdictions included undue influence as a statutory safeguard, therefore, consideration of the safeguards that sought to protect a voluntary decision in general were considered. At the conclusion of the comparative analysis, common themes were evident amongst the jurisdictions, which clouded the meaning of the terminology used and likely impeded the ability of the law to provide meaningful protection of a voluntary decision. With this in mind, it is recommended that South Australian legislature review the data available in other jurisdictions — discussed here in Part 2 — concerning the response to safeguarding a voluntary decision cautiously, through a critical lens, as this thesis has. It was observed in Part 2 that there was a sustained omission to define key terminology adopted to safeguard a voluntary decision in all jurisdictions.[16] Key terms were not defined and, as a whole, little insight into how voluntariness was assessed and confirmed was provided. The

[16] For an overview of the key terms used in each jurisdiction, see Table 8.

failure to define and clarify key terminology is a limitation with the respective laws, having the ability to blur and distort the efficacy of these key protections.

The previous VAD bills tabled in South Australia, outlined in Table 5, bore close resemblance to the legislative response operational in the US jurisdictions. In the US jurisdictions, protection against undue influence was an important element of the law.[17] However, based on intricate examination of the available evidence, no clarity or guidance was provided to either party regarding undue influence and it remains uncertain whether those called upon to analyse its existence actually understand what is undue influence. This position was viewed with great skepticism in this thesis. If the individuals called upon to examine undue influence, or certify that the person is acting free from undue influence in a VAD request, are not educated or informed as to what it is, then the efficacy of this examination is open to challenge. The lack of active engagement with the meaning of undue influence, and the failure to provide guidelines to facilitate assessment of it, serves to undermine the protective position of the law. The South Australian legislature proposed a similar approach by including protection against undue influence without defining or clarifying what it is, which, as addressed in the preceding chapters of this Part 3, were likely to pose significant risks to patients and medical practitioners.

It was never the purpose of this thesis to recommend one particular framework for safeguarding a voluntary decision that could be implemented in a prospective VAD bill in South Australia. The analysis undertaken in Part 2 identified concerning limitations with the response to safeguarding a voluntary decision, especially protecting against undue influence. It is, therefore, recommended that during the implementation phase of the *VAD Act* (SA), the Parliament of South Australia, or the body established to perform this task,

[17] For further discussion, see Chapter 9.

review the position adopted in other jurisdictions with regard to safeguarding a voluntary decision critically, which was the lens applied in Part 2. There is value in reviewing and learning the experience of VAD in other jurisdictions; however, this must be done cautiously.

The first step, not the last

[18.40] The purpose of this thesis was to critically examine undue influence as a proposed statutory safeguard, which served as the first step toward advocating for a more robust approach to safeguarding a voluntary decision for VAD. South Australia has taken the historic step of passing VAD legislation and has now set sail towards uncharted waters, thus it is critical that the legislative response to safeguarding a voluntary decision is clearly and unequivocally navigated. The risk of failing to do so is too high. This thesis took the first step by critically examining issues that arise concerning the proposed statutory response to safeguarding a voluntary decision against undue influence, serving as a cautionary tale regarding the careless adoption of terms such as undue influence. The next step is to now devise an appropriate statutory framework that can provide meaningful protection of a voluntary decision, as it is now evident that the legislative response was flawed.

Recommendations

1. It is recommended that the South Australian Legislature convene an expert panel to review reliance on screening for undue influence as a statutory safeguard for a voluntary consent. The response to devising an appropriate framework should not come from the legal profession alone but should be the product of a multidisciplinary panel of experts.
2. It is recommended that the South Australian Legislature review the legislative response to safeguarding a voluntary consent operational in other jurisdictions through a critical lens. There is a sustained silence regarding how the safeguards that aim to protect the voluntariness of the decision making process operate in practice. The reasons underlying this silence need to be the subject of critical examination.

Appendix 1

SEND A COPY OF THIS FORM TO THE OREGON STATE PUBLIC HEALTH DIVISION[1]

ATTENDING PHYSICIAN'S COMPLIANCE FORM

ORS 127.800 - ORS 127.897

MAIL FORM TO: Oregon State Public Health Division,
Center for Health Statistics,
P.O. Box 14050, Portland, OR 97293-0050

PLEASE PRINT

A 0	**PATIENT INFORMATION**	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH:
	MEDICAL DIAGNOSIS	

B	**PHYSICIAN INFORMATION**	
	NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER
	MAILING ADDRESS	
	CITY, STATE AND ZIP CODE	

C	**ACTION TAKEN TO COMPLY WITH LAW**	
	1. FIRST ORAL REQUEST FOR MEDICATION	
	Indicate compliance by checking the boxes	DATE
	☐ 1. Determination that the patient has a terminal disease	
	☐ 2. Determination the patient has six months or less to live (If less than 15 days, check here: ☐- see footnote 3.)	
	☐ 3. Determination that patient is capable[1]	
	☐ 4. Determination that patient is an Oregon resident[2]	
	☐ 5. Determination that patient is acting voluntarily	
	☐ 6. Determination that patient has made his/her decision after being fully informed	
	a) His or her medical diagnosis	
	b) His or her prognosis	
	c) The potential risks associated with taking the medication to be prescribed	
	d) The potential result of taking the medication to be prescribed	

[1] The Attending Physician's Compliance Form was downloaded from the Oregon Health Authority's webpage see Oregon.Gov, Death with Dignity Reporting Forms and Instructions, *Oregon Health Authority* (Web Page, January 2020) <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/pasforms.aspx>.

e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control

Indicate compliance by checking the boxes.

DATE:

- ☐ 1. Patient informed of his or her right to rescind the request at any time
- ☐ 2. Patient recommended to inform next of kin
- ☐ 3. Patient counseled about the importance of having another person present when the patient takes the medication(s)
- ☐ 4. Patient counseled about the importance of not taking the medication in a public place

Comments:

2. SECOND ORAL REQUEST FOR MEDICATION

*Must be **15 days** or more after the first oral request unless patient is exempt[3]*

DATE:

Indicate compliance by checking the boxes.

- ☐ 1. Patient made second oral request for medication to end life
- ☐ 2. Patient informed of the right to rescind the request at any time

Comments:

SEND A COPY OF THIS FORM TO THE OREGON STATE PUBLIC HEALTH DIVISION

ATTENDING PHYSICIAN'S COMPLIANCE FORM (continued)

	PATIENT INFORMATION	
	PATIENT'S NAME	DATE OF BIRTH
C	**ACTION TAKEN TO COMPLY WITH THE LAW – continued**	
	3. PATIENT'S WRITTEN REQUEST	
	Written request for medication to end life received (Please attach request) *(Must be at least **48 hours** before writing the prescription unless patient is exempt[3])*	DATE
	Comments:	
D	**MEDICAL CONSULTATION (Attach consultant's form.)**	
	Medical consultation and second opinion requested from:	
	MEDICAL CONSULTANT'S NAME / TELEPHONE NUMBER	DATE
E	**PSYCHIATRIC/PSYCHOLOGICAL EVALUATION**	
	*Check one of the following **(REQUIRED)**:* ☐ I have determined that the patient is not suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment, in conformance with ORS 127.825. ☐ I have referred the patient to the provider listed below for evaluation and consulting for a possible psychiatric or psychological disorder, or depression causing impaired judgment, **and attached the consultant's form.**	
	PSYCHIATRIC CONSULTANT'S NAME / TELEPHONE NUMBER	DATE
F	**MEDICATION PRESCRIBED AND INFORMATION PROVIDED TO PATIENT** *(To be prescribed no sooner than **48 hours** after patient's written request has been signed unless patient is exempt[3])*	
	Lethal medication prescribed and dose	DATE PRESCRIBED
	Please check one of the following: ☐ Dispensed medication directly **Date** _____ ☐ Contacted pharmacist and delivered prescription personally or by mail to the pharmacist **Pharmacy Name:** **City:** **Phone #:**	
	Immediately prior to writing the prescription, the patient was fully informed of: (check boxes) ☐ 1. His or her medical diagnosis ☐ 2. His or her prognosis ☐ 3. The potential risks associated with taking the medication to be prescribed ☐ 4. The probable result of taking the medication to be prescribed ☐ 5. The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control	
	To the best of my knowledge, all of the requirements under the Death with Dignity Act have been met.	
	X PHYSICIAN'S SIGNATURE	DATE

1. "Capable" means that in the opinion of a court, or in the opinion of the patient's attending physician or consulting physician, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating, if those persons are available.

2. Factors demonstrating residency include, but are not limited to: 1) possession of an Oregon driver's license, 2) registration to vote in Oregon, 3) evidence that a person leases/owns property in Oregon, or 4) filing of an Oregon tax return for the most recent tax year.

3. A patient is exempt from any waiting period that exceeds his/her life expectancy. The Attending Physician must have a medically confirmed certification of the imminence of the patient's death in the patient's medical record if any waiting periods are not completed. **IT IS THE ATTENDING PHYSICIAN'S RESPONSIBILITY** *to send the following documents to the Public Health Division: 1) Patient's written request; 2) Consulting physician's report; and 3) Psychiatric evaluation referral report (if performed).*

This form is revised periodically. To assure that you are using the most current version, please refer to http://www.healthoregon.org/dwd

CONSULTING PHYSICIAN'S COMPLIANCE FORM[2]

ORS 127.800 - ORS 127.897

Deliver this form to the attending/prescribing physician who will mail it to:

Oregon State Public Health Division, Center for Health Statistics,
P.O. Box 14050, Portland, OR 97293-0050

PLEASE PRINT

A	**PATIENT INFORMATION**	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B	**REFERRING/PRESCRIBING PHYSICIAN**	
	REFERRING/PRESCRIBING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER

C	**CONSULTANT'S REPORT**	
	1. MEDICAL DIAGNOSIS	DATE OF EXAMINATION(S)

2. Check boxes for compliance. *(Both the attending and consulting physicians must make these determinations.)*

1. Determination that the patient has a terminal disease.
2. Determination the patient has six months or less to live.
3. Determination that patient is capable.**
4. Determination that patient is acting voluntarily.
5. Determination that patient has made his/her decision after being fully informed of:
   - a) His or her medical diagnosis; and
   - b) His or her prognosis; and
   - c) The potential risks associated with taking the medication to be prescribed; and
   - d) The potential result of taking the medication to be prescribed; and
   - e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control. Comments:

D	**PATIENT'S MENTAL STATUS**

Check one of the following ***(required)***:

☐ I have determined that the patient is not suffering from a psychiatric or psychological disorder, or depression, causing impaired judgment, in conformance with ORS 127.825.

☐ I have referred the patient to the provider listed below for evaluation and consulting for a possible psychiatric or psychological disorder, or depression causing impaired judgment.

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[2] The Consulting Physician's Compliance Form was downloaded from the Oregon Health Authority's webpage see Oregon.Gov, Death with Dignity Reporting Forms and Instructions, *Oregon Health Authority* (Web Page, May 2018) <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/pasforms.aspx>.

	PSYCHIATRIC CONSULTANT'S NAME	TELEPHONE NUMBER	DATE

E	CONSULTANT'S INFORMATION		
	X	PHYSICIAN'S SIGNATURE	DATE
		NAME (PLEASE PRINT)	
	MAILING ADDRESS		
	CITY, STATE AND ZIP CODE		TELEPHONE NUMBER

** "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating, if those persons are available.

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Rev. 5/18

REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER[3]

I, _____, am an adult of sound mind.

I am suffering from _____, which my physician has determined is a terminal disease.

I have been fully informed of: my diagnosis; prognosis; the nature of medication to be prescribed and potential associated risks; the expected result; and feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending/prescribing physician prescribe medication that will end my life in a humane and dignified manner and also contact any pharmacist to fill the prescription.

Initial One

_____ I have informed my family of my decision and taken their opinions into consideration.
_____ I have decided not to inform my family of my decision.
_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request, and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

Signature:	County of Residence:	Date:

DECLARATION OF WITNESSES

By *initialing* and *signing* below, we declare that the person making and signing the above request:

Witness 1	Witness 2	
_____	_____	1. Is personally known to us or has provided proof of identity;
_____	_____	2. Signed this request in our presence on the date following the person's signature;
_____	_____	3. Appears to be of sound mind and not under duress, fraud or undue influence;
_____	_____	4. Is not a patient for whom either of us is the attending physician.

[3] The Patient's Written Request for Medication Form was downloaded from the Oregon Health Authority's webpage see Oregon.Gov, Death with Dignity Reporting Forms and Instructions, *Oregon Health Authority* (Web Page, August 2019) <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/pasforms.aspx>.

Printed Name: Witness 1	Signature:	Date:
Printed Name: Witness 2	Signature:	Date:

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a long-term health care facility, one of the witnesses shall be an individual designated by the facility.

PLEASE MAKE A COPY OF THIS FORM TO KEEP IN YOUR HOME

Copies of this form are available at: www.healthoregon.org/dwd Rev. 8/19

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